

Trans-forming Health Care in B.C.: Alleviating Barriers for the Gender Diverse

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Abstract

Available services and policies in B.C. fail to meet the needs of the gender diverse populations. A range of systemic and cultural barriers inhibits access to quality, gender-affirming health care. Twelve semi-structured interviews with trans-competent health professionals were used to identify barriers to accessing and providing gender-affirming health care; participants also identified a variety of potential policy options to address existing barriers. While broad cultural and systemic shifts were found to be central to improving the overall health and well-being of gender diverse clients, this study focuses on feasible, cost effective approaches that directly improve access to quality, gender-affirming care. The recommended policy suite is a trans-focused website connecting both providers and patients, developed in conjunction with a mentorship program enabling discourse and support among practitioners providing care for the gender diverse. This study focuses on the B.C. care environment, but the findings have implications for other marginalized groups in jurisdictions struggling with financial constraints.

Keywords: Transgender; gender diversity; health and well-being; health care system; B.C.; intersectionality

For KK:

You broadened my horizons just by being yourself.

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List of Acronyms

BC	British Columbia
CHC	Community Health Centre
CPATH	Canadian Professional Association for Transgender Health
DSM	Diagnostic and Statistical Manual of Mental Disorder
ICD	International Classification of Diseases
FFS	Fee- for – service
FTM	Female to Male
GIS	Gender Identity Disorder
GP	General Practitioner, or Physician
GRS	Gender Reassignment Surgery
MTF	Male to Female
MSP	Medical Services Plan
NP	Nurse Practitioner
RLE	Real Life Experience
SRS	Sexual Reassignment Surgery
WPATH	World Professional Association for Transgender Health

Glossary

Cis-gender	Refers to people whose sex assignment at birth is congruent with their felt gender identity
Female to male	A gender diverse person who has chosen to transition from a female gender identity to a male gender identity.
Gender affirming health care	Health care that affirms the clients' felt gender identity. This term refers to specific treatments that reduce gender dysphoria, but also requires that care be provided with respect and sensitivity given the immensely personal nature of this care.
Gender binary	The social construction of gender as limited to “male” and “female”, and the idea that these terms are opposite each other.
Gender clinic	Officially known as the Gender Dysphoria program, this program ran from the 1980s to 2002 in Vancouver, and provided an assessment and a wide range of services to gender diverse clients.
Gender expression	How a person communicates their gender identity to others through various forms of presentation, including clothing, behaviour, haircut, voice, and other methods.
Gender identity	A person's concept of self and how they perceive themselves – whether male, female, somewhere in between, or neither. Gender identity may differ from biological sex.
Gender identity disorder	Formal diagnosis used to describe people with gender dysphoria.
Gender diversity	Self-expression and identity that falls outside what is currently culturally perceived as a “gender norm”. Sometimes referred to as gender variance.
Gender dysphoria	Refers to feelings of discomfort, anxiety, or unhappiness about one's assigned gender (commonly known as biological sex), and the sense this assigned gender is different the internal gender that one identifies as.
Gender re-assignment surgery	Refers to a range of surgical procedures used to alter sexual characteristics to align with the felt gender.
Male to female	A gender diverse person who has chosen to transition from a male gender identity to a female gender identity.
Transgender	An umbrella term for anyone whose sex assignment at birth is not congruent with their felt gender, whose behaviour or identity differs from stereotypically perceived gender norms, or who <i>transcends</i> the convention definition of ‘male’ or ‘female’.
Transphobia	Discrimination as a result of a person having a gender identity or expression that differs from the sex assigned at birth.

Executive Summary

Health care for the gender diverse continues to fail to meet the demand for gender-affirming care in B.C. The closure of Vancouver's Gender Dysphoria Program in 2002 left significant gaps in care that have not been adequately addressed. Existing trans-competent practitioners and community supports are over-extended, and rural care options are extremely limited. Access to care is inhibited by a range of interconnected cultural and structural barriers that contribute to the disproportionately poor health outcomes among gender diverse clients.

This capstone focuses on improving the ability of the health care system and related supports to provide sufficient levels of quality gender-affirming health care and in the process, improving health determinants for this population. This research, through twelve qualitative interviews with trans-competent health and health related professionals, develops the understanding of provider side barriers to gender-affirming health care. The barriers identified include (1) a broad scale lack of knowledge and expertise among general practitioners and specialists – particularly mental health care providers; (2) significant structural barriers including the fee for services structure, the gender based framework, and the pathologization and categorization of gender diversity; (3) a lack of funding; and (4) a lack of communication and collaboration, specifically difficulty identifying providers and a lack of social support for trans patients and allies.

Given the need for immediate change in an environment of fiscal austerity, this project provides short term, feasible policy options that utilize the existing care framework and facilitate more effective employment of existing resources. The policy options generated through the interviews highlight the need for multi-pronged interventions, and thus a policy suite is recommended to improve the health of the gender diverse population in B.C. The suite consists of a trans-focused website developed in conjunction with a mentorship program. Together these policies provide accessible information, connect both clients and practitioners, and enable discourse and support among practitioners providing care for the gender diverse. However, improving the health and well-being of the gender variant population is a challenge that extends far beyond the direct purview of health policy. Substantive improvements in access to

gender-affirming health care are a long-term project, and will require foundational shifts in social and medical understandings of gender diversity.

1. Introduction

“Perhaps nowhere is the brutality of institutionalized transphobia so apparent as in the treatment of transpeople by the health care system” (Darke and Cope, 2002, pg. 37).

Health care for gender variant people—people who do not conform to societal gender norms associated with their biological sex—continues to fail to meet the demand for gender-affirming care in B.C.¹. Current levels of provision are insufficient and do not address the wide range of needs of this population; access to care is inhibited by a variety of barriers, and is highly unequal across the province (Kopala, 2003; heinz and MacFarlane, 2012). Access to quality health care can define the course of an individual’s life, highlighting the potential for serious long-term implications on quality of life and future opportunities as a result of barriers to care. The repercussions of a lack of access to gender-affirming health care for both gender diverse clients and society as a whole are immeasurable.

The care environment for gender variant people in B.C. has changed dramatically over the past decade. In 2002, Vancouver’s Gender Dysphoria Program, more commonly known as the Gender Clinic, was closed. The clinic had been providing assessment and treatment since the early 1980s for patients who met the criteria for gender identity disorder. The clinic was part of the Centre for Sexual Medicine, and provided a wide range of services, including endocrinological, urological/gynecological, psychiatric, psychological, and social services. Further, the clinic acted as the gatekeeper for public health coverage of transition-related surgeries, communicating

¹ Gender affirming health care is health care that affirms the clients’ felt gender identity. This term refers to specific treatments that reduce gender dysphoria, but also requires that care be provided with respect and sensitivity given the immensely personal nature of this care. Gender-affirming care is most likely to be provided by practitioners who have an understanding of gender diversity and who operate in the informed consent model, ensuring that clients have the information necessary to make an informed decision, and respecting client’s autonomy.

with the Medical Services Plan of British Columbia (MSP) about which patients would be covered for specific procedures. Closure of the clinic raised serious concerns from patients, providers, and transgender organizations about access to gender-affirming care. Following the closure of the clinic, a report was produced which examined the new care environment and proposed a series of recommendations (Kopala, 2003). The report pointed to a need for education and on-going medical training, formal mechanisms for collaboration between stakeholders, a professional advisory committee inclusive of trans- voices, better access to quality health information and available resources, attention to additionally marginalized sub-populations, financial assistance for peer support, increased adherence to standards of care, increased utilization of the harm reduction model, and the development of clinical guidelines, program evaluation and data collection, among others (Kopala, 2003). A decade later, most of the recommendations have not been realized. In the province of British Columbia services for gender diverse clients remain highly concentrated in Vancouver, and even within the core there are a lack of trans-competent providers able to provide basic care, such as endocrine therapy.² This dearth of knowledgeable physicians has produced concern about wait times to accessing care, as well as a lack of essential mental health supports.

In response to the void in available services, not for profit services have stepped in to try to address the unmet demand for gender-affirming health care. For example, in 2011, the Catherine White Holman Wellness Centre (CWHWC) opened in Vancouver. Staffed entirely by volunteer professionals, CWHWC provides a wide variety of health and wellness services to transgender and gender non-conforming people with a focus on minimizing barriers, such as catchment areas.³ The centre is currently exploring

² Endocrine (hormone-based) therapy seeks to “change secondary sex characteristics to reduce gender dysphoria and/or facilitate gender presentation that is consistent with the felt sense of self” (Dahl, Feldman, Goldberg, Jasperi, 2006, pg. iii). Hormone therapy is a commonly desired treatment for gender diverse clients, and has the potential to be a powerful, gender-affirming experience. Thus, it is considered to be central to care for gender diverse clients. It can be provided by primary care practitioners with appropriate training or in consultation with experts.

³ Community health centres are mandated to provide care to those who reside within their catchment areas, which means that trans- people who live outside of specific areas in Vancouver may be excluded from accessing care at these clinics. CHC’s also have a social element to their mandate, which means that there are a few exceptions to this restriction; for example, youth and patients with concurrent mental health issues or post-operative complications are exempted from the restrictions of the catchment areas.

sustainable funding models. The need for a volunteer clinic specifically to address the health care concerns of gender variant patients underscores the extreme need for change.

Improving health care for the gender diverse is a priority issue for a variety of reasons. The erasure of trans- identities means that the unique needs of trans- people are in danger of invisibility, and therefore are not addressed by provincial or federal policies and programs. Such invisibility has bred a dangerous lack of discourse about trans- issues, which leaves this growing population particularly vulnerable to marginalization. Gender diverse health care involves treatment specific to gender diverse clients, care that cannot be obtained without specifically educated providers. Further, the nature of this care has unique and particularly significant repercussions: for those who desire transition through medical treatment, the health care system is literally a gatekeeper to fully realizing this identity. The implications of barriers to accessing gender-affirming health care are therefore severe, and extend to mental health, employment, housing, personal relationships and beyond. The interconnected nature of these issues is an important dynamic that needs to be reflected in policy in order for substantive change to be realized. The established importance of social determinants of health, and the particularly influential impact that they have upon gender diverse people, have to be taken into account in the provision of health and related services and supports.

Perhaps, then, a reconsideration of what we consider to comprise a health care “system” is necessary. This research challenges the current Canadian conceptualization of the “health care system”, and identifies opportunities in a broader framing of systems and services that acknowledges and accounts for such highly interconnected determinants of health.

The need to seriously address the dearth of gender affirming health care is further supported by both equity and economic arguments. Canada’s health care system revolves around the equal provision of medically necessary services for all citizens, a standard that is not maintained with respect to gender-affirming health care for gender diverse clients, as the barriers to care described by this project highlight. The failure to provide equitable access to appropriate health care furthers the disproportionately poor

health outcomes of gender diverse clients, but also has cost implications for society as a whole. Poor access to medically necessary care, particularly within an already marginalized population, may result in increased utilization of other government supports and ultimately increase the burden on the taxpayer.

This project seeks to further the understanding of the range of barriers to gender-affirming health care and how to best respond to them in the current policy context of BC. This project focuses on identifying feasible, immediate steps to improve the health outcomes of the gender diverse population. Given this approach, a focus on care provision is appropriate since the health care system has the direct ability to counter detrimental effects of social determinants of health, and arguably houses more direct levers to realize change. Further, engaging with the health care system itself is particularly central to the experiences and marginalization of trans- people given its ability to provide gender-affirming treatment. While this capstone focuses on health care provision, it acknowledges the fact that health care is only one element of trans-experiences of health by utilizing a broad conceptualization of health. The health and well-being of trans- people must be understood contextually, reflective of the influence of social determinants of health. This project also recognizes that gender diversity is a social identity as well as a medical identity, and that health and well-being needs will reflect this complexity. The study focuses on provider- side barriers, interviewing a range of health and health-related professionals with significant experience working with gender diverse clients, and whose provision of care reflects the centrality of determinants of health.

The project utilizes an intersectionality framework, which draws attention to the relationships between categories of oppression, and the unique construction of identities produced through such layers of marginalization. The interrelated nature of marginalizing factors makes intersectionality a particularly valuable paradigm for the process of unravelling these barriers to health and identifying policy levers to provoke positive change. Intersectionality is also an appropriate framework for this project because it emphasizes the promotion of social justice and equity—the core motivation for this project. Given the clear need for immediate improvement in the health and well-being of gender diverse clients, and the climate of fiscal austerity, this project prioritizes the development of feasible, short-term policy options that can mitigate the barriers to

gender affirming care in B.C. Policy options focus on better harnessing the current human and fiscal resources, improving communication and collaboration between providers of all types of health and health related services, and increasing access to quality information about trans- health issues which reflects the diverse knowledges of trans- peoples.

This capstone is organized into 8 chapters. Chapter 2 provides a contextual background to gender diversity, including the impact of social determinants of health upon gender diverse people and the socio-cultural context in which this population attempts to access health care. It also examines different philosophical approaches to providing health care to gender diverse people. Chapter 3 explores current understandings of barriers to gender-affirming care as presented in the literature. Chapter 4 presents the research methodology employed in this project and explores the theoretical framework utilized throughout. Chapter 5 presents the research findings in detail, through a thematic analysis of the major barriers identified by practitioners. Chapter 6 outlines the policy objectives and options, while chapter 7 provides the criteria and measures used to assess the options in chapter 8. Chapter 9 concludes the project, identifies limitations to the study, situates the research contributions, and discusses future directions for research and analysis.

2. Background

2.1. About Trans-People

There are many different ways of being trans-. Some people who self identify as trans-, or who experience gender dysphoria⁴, may choose to pursue medical interventions in order to physically transition to their felt gender, whereas others may not. There are also many different paths that can be chosen in terms of transitioning to the desired gender. Some may opt for surgical options⁵, while other transgender people may choose to only undergo hormone therapy. Other gender diverse people may not undergo any medical care that is related to the expression of gender identity that differs from the sex they were assigned at birth. The most common medical treatment is hormone therapy, which masculinizes or feminizes secondary sex characteristics, such as voice, facial hair, muscle mass, and breast tissue (Spade, 2010). Such external markers of gender may be more important than genital appearance or function for some transgender people. There are numerous considerations involved in the decision about whether to medically alter one's body to align it with one's felt gender identity. Cost is a significant factor, as are health issues, healing needs, convenience, and personal preferences. Ultimately it is an immensely personal decision, and the nature of the choices that a trans- person makes about their gender expression should not affect the treatment they receive, through the health care system or in any other context. Clearly, what constitutes gender-affirming care depends on the specific needs of the individual.

⁴ Gender Dysphoria refers to feelings of discomfort, anxiety, or unhappiness about one's assigned gender (commonly known as biological sex), and the sense this assigned gender is different than the internal gender that one identifies as.

⁵ Surgery options include mastectomy (surgical removal of breasts), penectomy (surgical removal of penis), orchiectomy (surgical removal of testicles), hysterectomy (surgical removal of ovaries), breast augmentation, and gender confirmation surgeries (CGS) including neovaginoplasty (surgical construction of a vagina), phalloplasty (surgical construction of a penis).

The provision of such care must be dynamic enough to accommodate different experiences and needs.

The complexity of gender identity underscores the importance of understanding language used to describe gender and gender diversity. Confusion around gender identity often results from the conflation of gender identity with a variety of related elements. Spade and Wahng observe an attempt to “consolidate gender identity and expression, sexual orientation, gender, and sex all as one thing” (Spade and Wahng, 2004). For more on distinctions between these terms, see Appendix A. The word ‘transgender’ has often been used as an umbrella term for people whose assigned gender differs from their perception of self and/or socially expected behaviours associated with this gender (Kaufman, 2008). The word ‘trans’ has been used in an attempt to be inclusive of gender identities; the terms trans and transgender are widely employed in trans- communities (Whittle, 2006 in Dewey, 2010). Stryker, Currah and Moore use “trans-“ to emphasize the diversity of trans- identities:

A little hyphen is perhaps too flimsy a thing to carry as much conceptual freight as we intend for it bear, but we think the hyphen matters a great deal, precisely because it marks the difference between the implied nominalism of “trans” and the explicit relationality of “trans-,” which remains open-ended and resists premature foreclosure by attachment to any single suffix (Stryker et al., 2008).

This “explicit relationality” is important to the conceptualization of trans- that this project inhabits, and thus the terms trans- is used throughout this paper. The term trans-, as Shelley notes, “carries with it a sense of motion, movement...(which) explains the term’s appeal in...fields concerned with change” (2008) —which the realm of policy certainly is. Trans- as a term is thus doubly appropriate for this project. This project seeks to recognize the complex relationships between identities, and how these intersections further impact and often complicate the experiences of gender diverse people, people who may also be racialized, differently abled, sexually diverse, or who occupy other locations of marginalization.

2.2. International Context

Approaches to gender diverse health care vary significantly internationally. (Whittle et al., 2008). Increased use of information technology has helped to connect trans- communities, which have become both increasingly less isolated and politicized (Whittle et al, 2008 in Whittle 1998). Moreover, the 2008 Transgender Eurostudy⁶ found strong evidence that the trans population is “growing exponentially year-on-year”, noting that a majority of respondents had transitioned less than five years ago. Such data has clear implications for trans- healthcare and underscores the need to ensure the accessibility of quality, gender-affirming care. Results from the Transgender EuroStudy highlighted the layers of divergence in healthcare policy and philosophy between nations, which has resulted in a broad range of service responses to gender-variant populations. Nevertheless, the barriers facing trans people in accessing quality healthcare transcend borders and are, despite different political, economic and cultural contexts, remarkably similar.

To illustrate: the Eurostudy’s examination of the availability of information in Europe corroborated findings from the literature review of Canadian transgender health information—the fact that information is often quite difficult to find. Indeed, as Whittle et al. note: “(p)olicy in this area of medicine, including information about entitlement to treatment under national healthcare schemes, is not always made explicit” (2008), a fact which further exposes vulnerable patients to discrimination, as it obscures the availability of gender-affirming care and official care policies. The Eurostudy concluded that on the whole, nations required better coordination and increased levels of support in order to better treat trans- patients, otherwise “even practitioners with the best intentions may not know what specific treatments are available for trans people or how to plan the best way forward” (2008).

6 The Transgender EuroStudy was commissioned by ILGA Europe (The European Region of the International Lesbian and Gay Association), and used a mixed qualitative/quantitative approach to explore barriers to accessing healthcare for trans people. The survey involved 1954 self identified transgender people, and the focus groups involved 36 people throughout 27 European countries. This project is the largest and more comprehensive data collection on trans people’s lived experience to date.

The international environment with respect to trans- health care appears to mimic that in Canada: an evidence-based understanding of the gender diverse population and their needs is still being developed, as evidenced by the TransPULSE survey, the Vancouver Island Transgender Needs Assessment, the Transgender Eurostudy⁷ and the National Health Services' Audit of patient satisfaction with transgender services⁸. However, front-line workers continue to work to address the immediate needs of trans-clients by finding ways to provide quality gender-affirming care within the confines of “two-gender” health care systems; the benefits of such efforts are inhibited because they are not supported by a cohesive framework of care provision. Further, the knowledge and best practices developed by these efforts may be largely dependent on local context and difficult to translate into a broader policy approach. While research continues both nationally and internationally, hubs of care have emerged which have been foundational in developing standards of care and providing quality gender affirming health care. However, consistent policies or even frameworks of care provision are lacking at all levels of jurisdiction. This reality helps to explain the patchwork of services discussed in the following chapter. For more on differing approaches to gender diverse health care, see Appendix B.

2.3. Health Care: Only One Part of the Picture

Difficulty accessing gender affirming health care is only one of the many ways in which trans- people are discriminated against. It is, nonetheless, a central element in the marginalization experienced by many transgender people. The inability to access appropriate health care can aggravate and even perpetuate challenges in other areas of life, such as unemployment or unstable housing. Such areas of discrimination and oppression are interconnected and it is difficult to identify cause and effect within complex environments with many variables. This section situates the importance of access to health care within the context that necessitates it.

7 Other assessment surveys may be part of broader LGBT reports, such as Australia's Gay, Lesbian Bisexual and Transgender Health and Wellbeing Needs Assessment.

8 The National Health Services' Audit of patient satisfaction with transgender services was undertaken in 2008 by the UK's National Health Audit, Information and Analysis Unit. It identified similar areas of need to

Inability to access gender-affirming health care, including safe and effective hormone therapy, or surgery, can be a major barrier to trans- people living their lives safely and fully. Without such care, many trans- people have difficulty passing in their felt gender. This presents serious safety concerns, and opens up the potential of discrimination by current or potential employers. In the TransPULSE Survey⁹, 40% of respondents indicated that they were unemployed, unable to work, or considered themselves to be “underemployed”. In a follow-up survey focused on employment issues, 71% of trans- people had completed some college or university education, but around 50% make less than \$15,000 per year (Baeur et al, 2011). The Vancouver Island Transgender Needs Assessment also found that respondents were under-employed compared to the general population of B.C. (Heinz and MacFarlane, 2012).¹⁰ Prejudicial, trans-phobic culture within the workplace was cited as a factor in both trans- people declining work positions (17%), and in trans- people being rejected as a result of their trans identity (18%) (Baeur et al, 2011). Unemployment has been found to have significant negative impacts on mental health, and is connected to a loss of self-esteem, stigmatism and social exclusion (Unemployment and Mental Health, Institute for Work and Health, Ontario Workplace Safety and Insurance Board, 2009). Such intense marginalization has been found to increase the risk of suicide; suicide ideation among transgender people is disproportionately high—at 65% (Xavier et al., 2007).

Another impact of such underemployment and unemployment has been the entry of trans- people into sex work; approximately 15% of trans- people (both FTM and MTF) in Ontario have exchanged sex for money or life necessities like food or shelter (Bauer et al., 2007). Numerous reasons for engaging in sex work identified by trans- people include financial necessity (for both living and/or transition-related expenses), higher pay than could be accessed otherwise, reaffirmation of gender identity, and because it

⁹ TransPULSE is a community-based research project based in Ontario that occurred from 2004 through to 2010, focused on health issues experienced by a broad range of gender variant clients. The project involved both qualitative and quantitative components (focus groups, interviews, and surveys), and sought to provide information necessary to change policies in order to improve the health of trans people. The involvement of trans people was central to the project, which was framed as “part research project and part activist information network”.

¹⁰ A key challenge in employment for trans- people is providing proof of credentials and references, which is a common requirement. Of trans- respondents, 58% could not get transcripts with current name and gender; 28% could not get letters of reference reflecting current name or gender (Baeur et al, 2011).

provided feelings of community and being attractive (Bauer et. al, 2012). Of TransPULSE respondents who engaged in sex work, it was “generally regarded quite favourably”, and associated with empowerment (Bauer et. al, 2007, pg. 4-5). While there are a variety of reasons for trans- people to engage in sex work, their continued exclusion from the traditional job market means that it may not be a fully autonomous choice, but is merely preferable to significant financial distress, or other outcomes that are felt to be even less acceptable. Given that participation in sex work entails a high-risk level for physical and mental harm, involvement should be considered to be fully voluntary only when trans- people are able to access the same opportunities as cis-gender people. Currently, the decision to engage in sex work may be made in a context of layers of marginalization and limited options, potential for feelings of low levels of autonomy, and severe fiscal pressure.

Marginalization from the regulated and legal work force has other significant effects on transgender people. The culmination of the factors discussed makes trans-people disproportionately low income: TransPULSE data found that 55% of respondents had annual incomes of under \$20,000 (Bauer et al., 2007). In the Vancouver Island Transgender Needs Assessment, 62.9% of participants reported a personal annual income of \$30,000 or less, with the medium \$22,000 (Advisory Board for the Vancouver Island Trans Needs Assessment, 2012). Such low levels of income make transitioning especially difficult, as there are many associated costs that are not covered by Medicare¹¹. Accessing support services, such as emergency housing or shelter environments is further complicated by the fact that these are sex segregated spaces, where transgender people may not be welcomed in either male or female spaces, and where staying in these shelters may not be permitted (the rationale used being concern about having anyone with a penis in a battered women’s shelter), or may be unsafe (a

¹¹ There are numerous costs associated with transitioning that are not covered by Medicare, or which may not be covered depending on one’s income. Such expenses include but are not limited to: counseling, electrolysis, speech therapy, facial feminization surgery, travel costs to access care (which are not covered by MSP unless the client is on disability or currently receiving income assistance), doctor’s letters (necessary to access funding for MSP coverage for surgery and name change), legal fees (ex: change of name and updating all documents), medication costs (coverage dependent on client’s income and coverage; testosterone is expensive and often not covered). (Holman and Goldberg, 2006; Gender Outlaw: FTM Transition Blog, Transition Expenses).

transwoman who tries to stay in a men's shelter). Such situations illustrate the difficulty for trans- people to access even the most basic social supports.

Layers of marginalization have resulted in disproportionately high levels of incarceration among gender diverse people "as a result of police profiling, poverty, and the necessity of becoming involved in criminalized activities to survive" (Sylvia Riviera Law Project, 2007). The Transgender Community Health Project, conducted in 1997 in San Francisco found that 65% of respondents had a history of incarceration (San Francisco Department of Public Health, 1999).¹² In Canada, rates of incarceration are particularly difficult to gauge because "the Corrections Service of Canada does not keep statistics which they can retrieve" (Vancouver Prison Justice Day Committees, 2007).¹³ Moreover, the prison system itself is a sex-segregated space that by its very structure sets up transgender people for harassment and violence (Sylvia Riviera Law Project, 2007; Spade, 2009). Trans- people in both men and women's facilities have experienced high levels of harassment and violence, from both other prisoners and correctional staff (Sylvia Riviera Law Project, 2007; Spade, 2009).

Trans- marginalization is manifested at all levels of society, with a range of interrelated underlying causes. Ignorance of gender diversity, transphobia¹⁴, media misrepresentation¹⁵, and the widespread erasure of trans- experience continue to perpetuate an environment hostile to gender diversity that is not conducive to trans- health and wellness. Given such an environment, and the power of social determinants of health, improving the health outcomes of gender diverse people requires focused attention on eliminating society's discriminatory treatment of trans- people. This includes

¹²The Report of the National Transgender Discrimination Survey also demonstrated the clear impact of intersecting categories of discrimination, finding that rates of incarceration for participants who were both gender diverse and racialized were far higher than the overall sample—41% for black trans- participants and 21% for trans- Latino participants (Grant et al., 2011)

¹³ In one study conducted by the Prisoners HIV/AIDS Support Action Network between 1993 and 1999, approximately 10% of the HIV positive incarcerated clients identified as transsexual or transgender (Vancouver Prison Justice Day Committees, 2007).

¹⁴ Transphobia is discrimination as a result of a person having a gender identity or expression that differs from the sex that was assigned at birth.

¹⁵ In the 2010 report on media representation by the Trans Media Watch, 78% of respondents felt that the media portrayals of gender diverse people they saw were "either inaccurate or highly inaccurate".

for example, improving the ability of the health care system to minimize and mitigate the effects of such oppression through the accessible and equitable provision of gender-affirming health care.

2.4. Complex Relationships with the Health Care System

2.4.1. *Types of Care*

Trans- people are a diverse population, with differing health needs. Treatment generally revolves around the “triad” of therapy components:

1. Real-life experience in the desired gender role (RLE);
2. Hormone therapy of the felt gender;
3. Surgery to alter primary and secondary sex characteristics (Kopala, 2003).

Different people choose to undertake different elements of this treatment triad, and some may change their minds about their treatment preferences over time.

Approaches to delivery of gender transition-related health care can differ on a philosophical level. There are two main overall perspectives: the medical/prescriptive approach and the harm reduction/client-directed approach. The medical approach has been used in many gender clinics around the world, and places an emphasis on practitioner responsibility in determining appropriate candidates for gender transition. The practitioner utilizes specific psychological tests in order to determine a diagnosis in the *DSM-IV*, which is used as the rationale for recommending treatment (Devaney). Treatment with the medical approach is generally a linear process beginning with the diagnosis, followed by hormone therapy, varying periods of RLE (one to two years, but sometimes more than two years), and finally the potential of a variety of surgical options. The medical approach tends to follow more restrictive guidelines for care compared to the client focused approach, and sometimes may be more restrictive than the Harry

Benjamin International Gender Dysphoria Association (HBIGDA) standards of care¹⁶. Clinics and practitioners working from this perspective are often based in psychiatric hospitals and university settings, and are generally staffed by physicians. The framing of health practitioners as gatekeepers to trans- health care may stem in large part from care practices informed by the medical approach, where meeting specific—but sometimes inconsistently applied and value laden—criteria is often necessary to access specific treatments.

The harm reduction or client-directed approach differs fundamentally from the prescriptive medical model. It has evolved from the harm reduction model used to ensure that illicit drug users have access to nonjudgmental health care. Here, the health practitioner's role is not as a gatekeeper to care but as a support person to ensure that trans- people can make informed decisions about gender transitioning, to “employ strategies to reduce the negative consequences of medically unsupervised hormone use”, and to encourage consistent use of health care services (Devaney). Use of this approach tends to occur in community based organizations where there is a focus on addressing the multiple determinants of health that patients may present with—for example those who are racialized and living in poverty. Care is often provided collaboratively between a team of service providers that include health and social practitioners as well as physicians. Providers working in a harm reduction model may use the HBIGDA guidelines, but some providers with this perspective feel that it is an overly simplistic approach of their clients' needs (Devaney).

There is significant variation in the provision of treatment between approaches, but also within the same model and between providers. Practically, some approaches to providing care may combine elements of the different approaches. For example, some community-based programs may present themselves as progressive but impose restrictive standards for hormone therapy, such as the Fenway Community Clinic.

16 The Harry Benjamin International Gender Dysphoria Association (HBIGDA) Standards of Care for Gender Identity Disorders are a set of rigorous guidelines reflecting the consensus of a range of professionals about the provision of quality care to gender diverse clients. The broad treatment goal is “lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment” (HBIGDA, 2011).

Provision will differ between practitioner and between clinics regardless of their philosophical approach.

2.4.2. Erasure

The health care system's treatment of gender diverse people reflects the general societal erasure of gender diverse people and their needs and perspectives. Information and institutional erasure of gender diversity make accessing gender-affirming health care a difficult task. Institutions are common sites of marginalization through erasure. Bureaucratic frameworks, such as referral forms or intake forms, may be structured so that they deny the existence of or possibility for trans identities (Bauer et. al, 2009). This can have both mental and physical repercussions. State denial of the existence of one's felt gender and physical body is a painfully clear reflection of a society that literally has no place for you. Without state recognition of your identity and needs, accessing health care is difficult.¹⁷ The erasure of trans- people in health care contexts is mirrored in their experiences in public spaces; churches, recreations centers, pools, volunteer groups, shelters and other public spaces are often segregated by sex as well. Trans-people, however, may not physically fit the characteristics socially required to participate in either the male or female spaces; to do so may often risk significant harassment, attempts at shaming, and even physical danger.

Information erasure goes hand in hand with institutional erasure, and reflects the historical marginalization of trans- peoples' lived experiences. Though there is increasing recognition and understanding of trans- needs, such change is slow and occurs in a cis-normative context, where society and its institutions have revolved around the idea that gender is a static binary. The lack of trans- relevant and trans- focused information regarding health is a particular problem. Even when information is available, it is often

17 For example, participants in the TransPULSE survey discussed difficulties accessing specific services as a result of the sex designation on their provincial insurance card. The issue of sex designation on health related documents is a particular challenge. Billing systems are frequently structured to only allow billing for procedures which are affiliated with the listed sex. The result directly affects the ability of doctors to be reimbursed for treating transgender patients; for example, billing for a hysterectomy for a male patient or prostate treatments for a female patient may be impossible within the structure of the billing system (Bauer et al., 2009).

not readily accessible, and/or is not a standard component of medical education. Medical research has erroneously assumed that all research participants and patients are cissexual, and that this status is static. Trans- experiences are thus effectively made invisible, furthering social exclusion—which has serious implications itself (Baer et al., 2009). Exclusion from research processes has severely limited the amount of information on health issues and trans- people, especially those that are particular to trans bodies. Such a lack of information inhibits the ability of physicians to treat trans-patients effectively, and can foster discrimination or misunderstanding.

2.4.3. Pathologization

The pathologization of gender diversity seriously complicates attempts to access gender-affirming health care. Gender diverse people are often framed as being inherently mentally ill, which stems from the inclusion of Gender Identity Disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM).¹⁸ The inclusion of GID in the DSM, the terminology utilized, and the qualifying criteria have been consistently controversial among trans- patients, allies, psychiatrists, psychologists, physicians, insurance companies and other stakeholders. The pathologizing framing of trans-status is noted to act as a barrier to accessing care in several fashions: providers confuse GID with other psychiatric diagnoses, affiliate GID (due to its location in the paraphilia category) with mental illnesses predisposing individuals to crime, and assume that trans patients have or are more likely to have other psychiatric conditions (Snelgrove et. al, 2012).

The appropriateness of GID inclusion in the DSM, as well as the use of the term “disorder”, continues to provoke debate, as many stakeholders assert that the basic inclusion of a formal diagnosis in the DSM is stigmatizing in itself. The World Professional Association for Transgender Health (WPATH) has drawn attention to the implications of including GID in the DSM, asserting that “gender variance is not in and of itself pathological... having a cross- or transgender identity does not constitute a

¹⁸ The DSM, currently in the fourth edition, provides standardized categories and criteria for classifying mental disorders. It is widely used internationally and is considered to be the authoritative volume on this issue.

psychiatric disorder”. On the other hand, there is also debate about whether removing any reference to gender diverse people in the DSM would actually improve the access to quality care for this population. Lev highlights the complexity of the diagnosis and its implications, noting that:

On one hand, the diagnosis invokes challenging questions about the use of psychiatric diagnoses to label as mentally ill those with sexual behaviors and gender expressions that differ from the norm, and on the other hand, raises equally compelling questions about the ethics of using a psychiatric diagnoses within a manual of mental illness to provide legitimacy for transsexuals’ right to attain necessary medical treatments. (Lev, 2005).

The significance of including transgender in the DSM is underscored by the history of diagnostic criteria being used to support oppressive and discriminatory laws and public policies; such diagnoses were reflections of social norms or the personal prejudices of scientists.¹⁹ Framing GID as a mental disorder, through DSM inclusion, continues to have serious implications for gender variant people, but is an issue far beyond the purview of B.C. health care, given that decisions about diagnostic criteria are made internationally and reflect the decisions of a variety of experts and the current socio-cultural climate of the time.

¹⁹ For example, medical diagnoses helped to justify a ‘need’ for slavery and racial segregation, and were used to subordinate and abuse women; diagnoses such as neurasthenia and hysteria were considered to require treatments such as clitoridectomies and removal of the ovaries.

3. Barriers Identified in the Literature to Date

Research on barriers to gender affirming health care have mainly focused on patient side barriers to accessing quality care. Understanding trans- peoples' experiences in attempting to access gender-affirming health care, and their perception of the barriers to receiving the care they require, is essential to building a picture of lingering healthcare inequities, and to identifying potential areas and avenues for change. Existing literature presents only a limited picture of provider side barriers; thus, this project works to expand the current understanding of barriers inhibiting the provision of gender-affirming health care.

This section synthesizes the barriers to gender-affirming care as described by the existing literature, from both the patient and provider sides. Transphobia²⁰ is understood as presenting a barrier to accessing medical care in a variety of settings—primary care, substance abuse treatment, mental healthcare, and HIV treatment (2012). In a recent study, Shelley introduces a concept that is complimentary to transphobia: trans repudiation. While transphobia tends to be understood as the "sole motivation for social discrimination against transpeople", trans repudiation is "a process that intersects the interior (intrapersonal) with the exterior (interpersonal/*institutional*)" (Shelley, 2008, pg. 28, emphasis added). This is a broader, less causal²¹ way of understanding the layers of discrimination experienced by trans- people, which highlights the diversity of such experiences, while also drawing attention to the institutional, systemic nature of discrimination against trans- people. Indeed, "(t)rans repudiation is often not experienced as a clear and one-sided expression of prejudice, discrimination, and stigma" (Shelley,

²⁰ Transphobia is discrimination as a result of a person having a gender identity or expression that differs from the sex that was assigned at birth.

²¹ Shelley asserts that transphobia suggests a causal explanation for discrimination against trans- folks—the idea that the very presence of trans- people produces fear. While fear is certainly an element of many discriminatory experiences, the author concludes that there is a lack of evidence that indicates that all forms of trans-based discrimination are in fact grounded in fear.

2008, pg. 57). In Shelley's recent study, trans interviewees "while clearly able to identify transphobia itself, indicated that (trans repudiation) is frequently tied up with other intersectional issues based on racialization, class, sexual orientation, and ability" (2008, pg. 57). Thus, trans repudiation can be difficult to identify or isolate, but appears to be a consistent and pervasive barrier to accessing gender affirming health care.

Trans repudiation as a barrier to care may be highly interconnected with other barriers experienced by trans- people. The dearth of knowledgeable healthcare providers is readily acknowledged, and is an issue at all stages of care— in primary care, with specialists, and in emergency care. A provider's predominant focus on a person's trans- identity or specific elements seen as related to this identity, regardless of medical relevance to the issue the patient presented for, has been noted as being traumatic for trans- patients (Shelley, 2008). It further presents a barrier in that such negative experiences with a provider may render trans- patients reluctant to seek again—for any health issue, which can have devastating consequences (Kaufman, 2008). Sanchez avers, "the insensitivity of health care providers is the primary reason why transgender people do not access services (2002, cited in Greatheart, 2010). Greatheart goes on to assert that trans- people tend to begin to access health services only when it is clear that the environment is both trans-friendly and trans-competent (2010).

Financial funding is another issue that has consistently presented a barrier for those seeking to access gender-affirming health care, particularly regarding health care needs related to transitioning. Funding of surgeries for trans- people is a heavily politicized issue, regardless of whether the treatment is unique to trans- people or available in other contexts as well.²² Since health care is provincially governed, there exist significant provincial inequities in what procedures are covered by provincial health insurance. In addition, the limited availability of surgeons who can perform particular surgeries furthers the provincial inequity of access to gender-affirming health care. For example, all Canadian patients who wish to have phalloplasty (performed nationally)

²² For example, specific surgeries are often de-listed and or re-listed depending upon the political party in power. In 2012 B.C. insured phalloplasty for five patients, but vaginoplasty remains an out of pocket cost; there is inequity of funding even between types of procedures as well.

must travel to Montreal—a trip that is more costly and inconvenient the farther west one resides.

Patient side barriers should be examined in concert with provider side barriers, given that these barriers are deeply interrelated. Provider side barriers are particularly important given that providers may have unique, in-depth knowledge about the system itself, and be able to identify barriers only visible from within the bowels of the system. Research on provider-side barriers to gender-affirming health care is extremely limited. A 2012 Ontario based exploratory study sought to begin to fill the gap in literature, and focused specifically on physician-side barriers. Qualitative interviews were conducted with physicians about the perceived barriers to providing trans- health care. This study focused strictly on health care professionals, which limits the scope of the findings. Interview participants were restricted to general practitioners and specialists, and close to 40% of the participants had no known experience caring directly for a trans- patient (Snelgrove et al., 2012, pg. 4). Inclusion of providers with no known experience providing care for trans- patients may mean that the number and diversity of barriers identified, and the discussion of potential solutions is greatly diminished, given that these providers have no experience treating trans- patients, nor navigating the system with respect to trans- health care. Despite its limitations, Snelgrove et al.'s study is an immensely useful starting point, and the findings are well worth exploring. Physicians identified a number of barriers to the provision of care, including identifying and accessing resources—including referral networks—, as well as significant knowledge deficits, particularly with regard to trans- specific health issues. There was considered to be a lack of formal education about trans- healthcare in medical school and residency curricula. Ethical concerns were raised as well, in that while medical knowledge is required to guide the transition process, “physicians feel uncomfortable influencing a person’s choice to pursue treatment or not” (Snelgrove et al., 2012, pg. 6), given the significance and potential ramifications of a transition. This project expands the current understanding about provider barriers by utilizing a broader definition of health, and including a range of trans-competent providers among the interview participants. Further, it specifically focuses on the perspectives of practitioners experienced in providing trans- health care, ensuring that detailed, system-specific knowledge informs the identification of barriers and potential policy solutions.

4. Methodology

This research utilizes a qualitative research methodology, exploring the barriers to gender affirming care in British Columbia. Qualitative research is appropriate given the immensely complex and intimate nature of trans- health care, where language is an effective form of exclusion, and the identities, challenges and needs of gender variant people are still in nascent stages of understanding by researchers. The primary methodology for this project consists of expert interviews (n=12), which are used to ensure a thorough understanding of the policy environment, barriers, and opportunities in a B.C. context.

4.1. Theoretical Framework

This research is informed by an intersectionality framework, which provides a uniquely appropriate structure for examining issues related to trans- health. This perspective is grounded in the promotion of equity, and conceptualizes human experience in a fashion that validates and embraces gender variance. An intersectional approach sees social categories—such as gender— as “socially constructed, fluid, and flexible”, which breaks down the gender binary so central to trans-phobic thinking (Hankivsky et al., 2012a). The framework also acknowledges diversity within such categories, emphasizing that individuals are frequently part of multiple categories, and that these experiences interact and affect each other, as opposed operating in a basic additive approach. Intersectionality draws attention to the relationships between categories of oppression, while avoiding prioritizing specific elements. The social identities/locations that are produced cannot be unravelled, and are continually re-constructed in the particular context—impacted by time, space, and power (Hankivsky et al., 2012a).

Power is an important element in intersectionality, as it “operates at discursive and structural levels to exclude particular knowledge and experiences” (Foucault, 1977, in Hankivsky et al., 2012a), and creates hierarchical social categories. Collectively these processes structure experiences of privilege between and within groups. Intersectionality emphasizes that power relations are complex and multi-dimensional. Being marginalized in one context does not exclude one from being the oppressor in another context, and collectively resilient in yet another, challenging binary perspectives that frame specific groups against others, such as men vs. women (Hankivsky, 2012c). Indeed, Shields asserts, “intersectional identities are “relationally defined and emergent”, and emphasizes the need to recognize that intersecting identities can produce unique and stable “hybrid” identities (2008).

Intersectionality as a methodological framework is particularly valuable as it enables a more nuanced—and ultimately accurate—understanding of gender diversity. Diamond and Butterworth assert “perhaps the greatest potential contribution of intersectionality to our understanding of transgender experience is the way in which it recasts and reconstitutes the phenomenon of change” (2008, p. 375). Experiences of change, they note, are not limited to transition experiences but are “an ever-present possibility”. Intersectionality provides further insight into the marginalization of gender diverse people through the concept of *intersectional invisibility*. Eibach and Purdie-Vaughns observe that because people with multiple subordinate-group identities (ex: transgender women) “do not fit the prototypes of their respective identity groups” (ex: transgender, women) they will become effectively “invisible”, recognized fully by none of their respective identity groups (2008). Intersectionality requires venturing far outside one’s own social locations and comfort zone; indeed, Walker observes “the attempt to understand intersectionality is, in fact, an effort to see things from the worldview of others, and not simply from our own unique standpoints” (2003, p. 991 in Shields, 2008). Intersectionality presents an immensely valuable and appropriate framework for this research about trans- health, particularly since it is undertaken by a cis-gendered ally, and provides an important reminder to researchers to be diligent in examining the roots of our privileges.

4.2. Interviews

4.2.1. *Participants*

The study involved interviews with health professionals with experience with gender diverse clients. The category of health professionals is used in a broad sense, reflecting the importance of social determinants of health; professionals whose work addresses social determinants of health were included in the interviews. These professionals were chosen because they have an understanding of the health care options available to gender diverse clients, as well as the political and social care context and barriers to care experienced by this population. Selecting professionals who have experience working with trans- people increases the likelihood that they will have valuable insights about policy approaches that should be explored.

Gender diverse individuals were not interviewed on the basis of their gender identity for two reasons. First, research has been conducted which focuses on the needs of transgender people—health focused and otherwise.²³ Second, the short time frame and lack of resources made conducting a sufficiently rigorous and ethical survey with gender diverse people difficult, given the history of helicopter research²⁴ among this population, and the resultant “research fatigue”.

In total, twelve participants participated in this study. Four were physicians – all currently practising physicians who have significant experience working with trans patients; four work in Vancouver based clinics which provide primary care to trans patients. One participant was a Nurse Practitioner with experience providing health care to trans- patients; one was a professor heavily involved in the trans community and in

²³ High quality research on Canadian gender diverse populations have occurred recently through the TransPULSE Survey in Ontario and the Vancouver Island Transgender Needs Assessment. These studies have provided rich data sets about the experiences of trans-people in Canada, their interactions with the health care system, and their evaluation of their needs.

²⁴ Both the health community and researchers have a history of “helicopter research”, where the researcher utilizes the community for a specific purpose and benefits personally from the research, but where the community gains little from sharing personal and sometimes painful information with the researcher. Here, the participants are often treated as ‘subjects’, which may remind of their continued marginalization. Research with gender variant people thus needs to be conducted in a community-based participatory fashion.

trans- needs research. Two participants were clinical psychologists with significant experience providing care to gender diverse clients. Four were community workers for LGBT groups, and provided services directly to trans clients – one was involved with a program focused on trans health needs, and one was a coordinator of a B.C. rural trans education program. Four participants identified as transgender, whether by stating this during the interview or by including this information in their professional work; one cis-gendered participant was in a relationship with a trans- person and highlighted that their understandings were coloured by this experience. No questions about gender identity, sexual orientation, or relationship status were asked during the research, and while it may be possible to presume that the remaining participants were cis-gendered, this was not determined clearly in the research. In any case, a minimum of 36% of the research participants self identified as trans-. All of the participants but one were located in B.C., 7 were working in Vancouver, three were located in B.C. but no longer worked in Vancouver, and one was working in Toronto.

4.2.2. Confidentiality

Ensuring the confidentiality of interview participants was a priority, particularly given the limited pool of trans- competent health professionals and the subsequent increase in potential for identification. A number of participants indicated their willingness to have their information shared publicly, whereas others emphasized the importance of confidentiality to their participation. None of the participant's real names have been used at any stage of this research, and pseudonyms are used throughout this document. Further, no affiliations with organizations or employers are mentioned. Each participant, again to prevent unwanted identification in a small field, has also explicitly approved the specific professional designation utilized. Participants acknowledged that given the small size of the trans- health care community, their identity might be subject to speculation, but were comfortable with this possibility. Some even noted that their perspectives were already well known and that they “had nothing to hide”.

4.2.3. Recruiting

Recruiting of health professionals occurred in two ways: through letters of invitation and through snowball sampling. Letters of invitation were shared with

professionals identified as having experience providing services to the transgender population; their contact information was found through public sources. In snowball sampling, initial participants pass on my contact information to potentially interested colleagues who may contact me directly if they choose. Interviews are conducted in the format preferred by the participant. A semi-structured format was used to encourage flexibility in the discussion, and to allow participants to emphasize issues that they deem to be important. Questions focused on the experiences of health professionals working with gender variant people, changes related to local shifts in transgender health care structure, the barriers to access of gender-affirming care, and potential policy solutions to specific barriers, particularly their political feasibility and effectiveness. An interview schedule with questions and prompts is available in Appendix A. The interviews helped to inform a thorough understanding of factors preventing change and to develop and evaluate potential policy options that can address the layers of barriers identified.

5. Interview Findings and Analysis

Interview participants demonstrated varying degrees of awareness about diversity among the clients with whom they work and interact. Overall, the interviews revealed limited explicit attention to diversity in social locations and structures within the population. Indeed, the lack of attention to trans- needs as a whole obscures the need for attention to diversity within this oft marginalized population. Given the barriers to providing and accessing basic levels of trans- health care participants had limited ability to attend to the different needs of specific groups of trans- people. To a large extent, participants appeared to discuss “trans- needs” as a singular body of consistent needs as opposed to a diverse range of needs dependent on a variety of other factors. The implication is that achieving greater recognition of gender diversity and increasing broad trans- competency is the primary concern, and a goal that would benefit all gender diverse people—although some more than others. This is particularly problematic given the broad-spread marginalization of trans- people across health and social support systems: occupying multiple locations of oppression severely inhibits one’s ability to access services related to gender diversity because such services may be designed based on a limited understanding of what this gender identity might mean or encompass.

One participant directly acknowledged the need to attend to variance of social location in trans- related policy, noting the different experiences with gender diversity that result from intersections with different identities:

...my voice is particularly loaded, because I’m a trans dude, and I’m white and physically able bodied, so there is all this stuff that doesn’t get represented in the ways that I talk about trans experience...We know that trans people are disproportionately unemployed, underhoused, under – all these things. And it’s not just trans people across the board, it’s trans women, trans people of colour, folks who are already experiencing marginalization...(Justin, Trans program coordinator).

Other participants signalled the importance of attending to social locations and structures, underscoring the fact that gender diverse people are not a homogenous group, and that their needs will differ between individuals, over time and depending on geographic location. Such undertones highlight the fact that there are other considerations alongside gender diversity to be incorporated into the provision of care and the development and implementation of policy.

Some locations and intersections appear to be more directly addressed than others, as evidenced by both the interviews and by current policies. Gender diverse and non-conforming youth were considered to merit particular attention: current care policies in Vancouver based community health centres allow youth (up to and including age 24) from different catchment areas to access care, whereas adults are restricted to accessing care in their catchment area. Geography was another particular concern for participants, who emphasized the importance of addressing the needs of clients outside the Lower Mainland, and particularly in rural and remote areas. Interview participants frequently lamented that services were overwhelmingly geared towards gender diverse people who intended to transition or who were transitioning. Further, the specific difficulties of providing and finding additional care for trans- people with co-morbidities were also highlighted. Such observations demonstrate provider concern for the unique implications of gender diversity in the context of specific, interacting social locations. Some providers may be more experienced in attending to such locations as a result of the environment in which they provide care, though this was not explicitly discussed. In Vancouver, several community health centres take the lead in providing care trans-health care; their structure deliberately caters to clients occupying complex, multiple social locations and experiencing layers of barriers to care. This allows practitioners at such facilities to better address the implications of social locations for clients—including those who identify as gender diverse.

This study is grounded by the intersectionality paradigm in order to acknowledge and draw attention to the diversity within the gender diverse population, and the resulting complexity of intersecting social locations and subsequent unique needs. On the whole, overt consideration of complex and intersecting social locations by the interview participants was limited, and the discussion around these issues reveals that concern about social locations in the context of gender diversity may appear secondary to the

pressing need to improve awareness of gender diversity in a broad sense. This research explicitly reveals the importance of improving basic trans- health care, while highlighting the need to consider the diversity of the gender diverse community in providing care—one size does not fit all.

5.1. Provider Perceived Barriers

As detailed below, interviews with a range of professionals produced an extensive list of barriers perceived by those seeking to provide gender-affirming care; barriers to both accessing and providing gender affirming health services were identified. The results of the interviews expand upon the literature, provide specific policy recommendations, and identify best and promising practices.

5.1.1. *Lack of Knowledge and Expertise*

An overall lack of knowledge and expertise regarding trans- health care was a consistent trend throughout the interviews. This lack of knowledge of trans- issues is evident in a number of fashions: a lack of societal awareness and acceptance of gender variance, a lack of practitioners able or comfortable to provide gender affirming primary health care, and a lack of trans-competent experts.

Participants consistently identified a general lack of awareness of trans- issues and the concept of gender identity among health care professionals, the public, and policymakers. The results of this foundational incomprehension of gender dysphoria are innumerable, and help define the experiences of trans- people in the health care system and in society. The lack of broad societal understanding of gender diversity means that trans- health issues are treated differently, as both public and professionals grapple with the concept of gender diversity. As explained by one of the participants:

(i)t's... different, and society is still— taking hormones for menopause is okay, but taking hormones to change your gender appearance is really weird....doctors still feel like they are making a big decision when they are deciding to support somebody to do this. (Justin, Trans- Program coordinator).

Participants noted that among primary care providers there is a lack of understanding about *how* to provide appropriate care. Indeed, without a foundational level of understanding of gender variance, providing health care—whether general or unique to trans- clients—may appear to be out of reach or even inappropriate to physicians inexperienced with this type of care. The idea that providing treatment to trans- clients, which can often involve prescribing hormone therapy, needs to be done by specialists or general practitioners with significant experience prescribing hormones appears to be common. Many practitioners observed, as did the following participant, that:

...people often see (trans- health care) as a really specialized area that only gender specialists can attend to. They feel it's... about their capacity. I totally don't agree with that. I think that trans-care is totally within the realm of primary care. Family physicians, nurse practitioners with a little bit of extra training can definitely provide this care...an interdisciplinary kind of shared care model works really well. But I definitely think it should be within primary care and not a specialty. (Dr. M, General Practitioner).

The lack of understanding about how to go about providing health care for trans-patients has produced a lack of health professionals providing gender affirming health care in the province. This has further bred “a dependency on Vancouver-based services for health care” (Liz, community worker with trans- support focus), leaving current Vancouver providers sometimes over-whelmed by demand, while severely limiting the access to care for patients in other health authorities. One practitioner elaborates on this issue:

There also used to be this fear that if you overloaded...sometimes one doctor, especially up in the interior, will say, “Okay – we'll put somebody on hormones”. And then they're like the next day, 10 people called...they can kind of freak out, right? So sometimes you don't want to (be that person)... you don't want to spread their name around because they might just say, “Okay – no more. I'm not going to do that again.” So we want to... cultivate those relationships (Dr. M, Clinical Psychologist).

Vancouver based participants noted that the Vancouver Coastal Health authority is more focused on providing health care to gender variant patients than other health authorities in the region, which has implications for VCH providers and patients in all authorities. As one Vancouver based physician notes:

...(y)ou want people to get care close to their community...talk about barriers! ...Vancouver Coastal Health does the lion's share of transgender health for the bulk (of the region)...(the) Fraser Health Authority is woefully under-involved and we get lots of people from Fraser Health...So one of the barriers is the other health authorities don't put it on their agenda in the same way that Vancouver Coastal have. But the reality is we've got more... people with gender identity issues...It's just you kind of get a little ticked off... not everybody's pulling their weight, but they also don't have the same volume. (Dr. D, General Practitioner).

Participants traced the widespread lack of knowledge among providers back to medical school, and many noted that the amount of education provided formally through schooling was minimal, if any. As a result, one general practitioner asserts that:

...a lack of education is a major barrier for a lot of physicians. I think many people will come out of their...undergraduate medical training and out of their residency without having learned anything at all about trans-health. It's amazing to me that that can happen but it does happen.... People just don't have the education. (Dr. M, General Practitioner).

The feeling that medical school is the proper place for education about gender diversity and related health issues was also underscored by some participants, who noted that once practicing, providers are simply too busy. Medical school and residency are framed as learning endeavours, and students are generally more open to learning than physicians already providing care. It follows that people will be more open to learning about new concepts when in structured, educational environments. Underscoring this reality, one participant recalled the strategy that was utilized after the closure of the Gender Clinic in 2002 in order to get more physicians providing gender-affirming care:

....(the) idea was to train people who were already working. Instead of being a speciality, (trans-care) would just be one of the services that you provided. (It) didn't work though because most GPs are so busy that they can't even take new patients. So why would they want to learn how to do something new that's kind of "iffy" and a little bit...it really confronts you when you haven't been exposed to gender variance and then all of a sudden you have to re-examine yourself, you re-examine your gender. It changes the way you see the world. There's some intellectual work involved and not everyone wants to do that, you know? ... So it's been really hard to find people that want to (provide trans- care) (Dr. M, Clinical Psychologist).

Clearly, there are layers of challenges stemming from a lack of fundamental education about transgenderism. Practitioner discomfort with gender diversity is perceived to be a barrier to provision, as one participant observes:

we've developed four days of comprehensive clinical training for providers and even after taking those days — which is more training than you get in med(ical) school for doing emergencies training for emergency situations — doctors are still unwilling to prescribe, so its like there — there is something *there*... Our biggest push has been that this is primary care, it's not complex medicine, you give hormones to people all the time for all sorts of things... and doctors are like “mmmmm, we don't feel comfortable”. So that has been a huge barrier (Justin, Trans- Program coordinator).

It is notable that such discomfort is present even among providers who have expressed an interest in expanding their knowledge about how to care for trans- patients, and who have participated in education programs.

Participants noted that the lack of trans-specific training also extends to experts. There is a dearth, nationally and provincially, of specialists who have an understanding of gender variance, as well as specialists in trans- care who are able to perform trans-specific surgeries. The idea that only experts should be providing care to trans-people is particularly problematic given the lack of specialists. One participant observes that:

...a lot of people feel if they have a trans-person present for care and they aren't quite sure what to do but want to be supportive often what they'll end up doing is trying to make referrals into these systems...like... psychiatry and endocrinology...(where)...broadly speaking there's very few people...that want to see trans-people either. So even going that route sometimes leads to more and more barriers for people... (T)here's only certain specialists within those specialties who will take trans-people into their practices. (Dr. M, General Practitioner).

Many participants expressed frustration with the lack of capacity for performing genital surgeries for trans-clients, agreeing with this physician that:

...(T)here should be at least two or three surgeons with capacity to do some of the gonadal reconstruction surgeries (Dr. T, General Practitioner)

Currently, genital surgeries—even those covered through Medicare—are only available through a private clinic based in Montreal. Clients must pay for the financial costs of travel in addition to bearing the psychological and physical stresses of having major surgery away from home, with unfamiliar health professionals, and without one's support system. Participants consistently expressed their concern and confusion over the existence of a B.C. based physician understood to have the appropriate training to perform sexual reconstruction surgeries, but who is not currently performing them. A lack of bed-space and surgery time was understood to be the barriers in providing surgeries within the province.

Participants also noted a significant lack of trans-competent mental health professionals. Mental health was identified as a vital—but missing—component of care available to gender variant clients, as this clinical psychologist notes:

I think that's part of the flaw of the model that they're using in Vancouver - that 'Vancouver model'. There's no mental health in it. (Dr. M, Clinical psychologist).

The absence of mental health supports for the gender variant population was widely identified as a problem for clients requiring a range of support levels, but support was found to be particularly difficult to locate for complex cases, as this participant observes:

An example is I have a transgender patient right now who identifies more as male; as female to male but (has been) really struggling for a couple of years: questioning about their identity or not, really not sure, maybe even thinking they had some level of autism, social depression, anxiety and some anti-social personality traits—a whole bunch of stuff; and trying to try and find free assessment counselling was incredibly difficult; trying to find resources of people who understood trans and could give assessment at low costs. And she actually had absolutely no income so we never had the people to... (help)...Money is the issue (Jane, N.P.).

In this particular example, the lack of accessible, trans-competent mental health support meant that the client utilized primary care professionals in lieu of mental health professionals; substituting primary care when mental health care is required (even out of necessity) both over-taxes the limited number of trans-competent primary care providers, and may mean that the client does not receive the kind of care that is required.

Further, participants consistently emphasized the need to access mental health support throughout the transition process—before, during and after—as well as not in conjunction with transition if they do not transition. In addition, access to mental health care only at the surgical assessment stage further establishes the “gate-keeping” dynamic between the patient and provider, as opposed to framing the interactions as a collaborative health treatment process where the patient has both agency and support.

5.1.2. System Structure

The structure of the health care system was developed prior to understanding of gender diversity, and so does not reflect the needs of this population. Underpinning the structural barriers is a general lack of awareness about gender diversity.

Fee For Service Structure

The FFS structure presents challenges to the health care system that are far beyond the scope of this project, but the impact on trans- patients, who already face social marginalization, is clearly significant. Participants noted that the lack of physicians providing hormone therapy might be in part due to a lack of financial incentive:

G.P.s do not make enough per visit to actually support the type of counselling that needs to be done over several visits” to properly provide hormone therapy...in health care family doctors get \$30 per minute per visit....so if you spend 45 minutes with someone...\$30 that actually covers your overhead. So there is a huge disincentive there...the economic drivers don't match the type of care that we're supposed to be giving (Dr. T: Physician- G.P.).

The fee-for-service (FFS) payment structure currently in place means that there is an incentive for physicians to see a larger volume of patients, therefore patients requiring complex and time consuming treatment, which hormone therapy may be or may be perceived to be, can be less appealing. Trans- patients may be perceived to be particularly complex cases, especially to physicians without prior experience.

For trans- patients, FFS exacerbates other barriers to care; if physicians are already unsure about their ability to care for trans- patients, the financial disincentive may provide (further) justification to pass the patient onto another provider. In addition,

given that some providers may need to independently seek further education on gender care in order to provide hormone therapy, the lack of financial incentive to provide this care may ultimately encourage a provider to refer the patient elsewhere—further delaying care.²⁵

Gender-Based Framework

The structuring of the health care system around a binary concept of gender produces a variety of barriers to providing gender affirming care, and inhibits the compassionate delivery of services. Participants noted that the two–gender framing of health services results in delivery practises that can be demeaning for the patient, but also complicate the provision of care. There are a variety of ways that the gender-based framework inhibits effective and efficient care, for example:

Unless you get (the gender on your care card) changed so your lab results... can come back normal for a female or abnormal for a female depending on whether you're identified as a male or a female in the system. So I'm constantly having to explain that but the reality is if you have the anatomy, the internal anatomy of the female, you still have ovaries then you still have to account for the effect of the female hormones and therefore keep track of that. (Dr. D, General Practitioner).

Gender based division of space in health care facilities is especially problematic for patients, and can be a deterrent for accessing care:

If a trans guy goes in to see a gynaecologist it's "So what's a guy doing here?"...That's a really hard thing because the system isn't set up. You know it's always been set up in... (a) binary male or female (manner) so it may be a perceived challenge...(Dr. D, General Practitioner).

²⁵ The issue of funding was noted to be a barrier only for doctors who are paid through the FFS mechanism. Community health centres (CHCs), used in health authorities across the province, tend to have alternative payment mechanisms, such as sessional payment (payment for a certain number of hours in a session, regardless of the number of patients seen in this time frame), or salaried payment. CHCs are designed specifically for patients who experience barriers in accessing health care—patients who are marginalized as a result of issues such as addiction, homelessness, mental health, HIV/AIDS status and/or gender issues. As a result, the payment structure of CHCs specifically ensures that they are able to provide complex care that is often restricted by the FFS schedule. Nurse practitioners, who can provide levels of primary care for trans- patients largely similar to physicians, are paid by salary as opposed to the FFS model.

Overall, such dilemmas contribute to the perception of exclusion of gender variant clients, though they are built into the system and not necessarily reflective of active discrimination by health care workers. As one participant observed: “the system hasn’t been particularly sympathetic or welcoming to gender variant patients”. Participants also noted that cultural understanding of gender as binary underpins the broader system structure.

Pathologization and Categorization

The pathologization and subsequent categorization of gender variant identities produces significant barriers to accessing gender affirming health care. The inclusion of GID in the DSM categorizes gender variance as a mental disorder, which inhibits patients from accessing care (or care covered by MSP) if they do not want to present themselves as having a mental disorder. Such pathologization adds to the gate-keeping experience of gender diverse clients seeking to access treatment. Participants noted that as a result of this pathologization, and subsequent hoop-jumping required to access care, clients were extremely cautious about how they presented themselves. As one practitioner observes:

...if you want health care specific to being trans-gender you have to kind of go through these hoops if you want to get on hormones, if you want surgery or if you want any of these things and people have historically been expected to kind of conform to this idea of what it means to be trans and how to fit in to this gender identity diagnostic category and you know feeling that they need to sort of hide parts of themselves to actually get the care that they want and need...(Dr. A, General practitioner).

This can inhibit the development of a strong and open relationship with the provider, potentially degrading the quality of care - because clients may feel unable to be totally open and honest about their experience, needs, and concerns. The issue of editing their experiences, or physical health or mental health status is a particular concern for patients dealing with mental health challenges. As a result of the structure of the health care system, and its systematic pathologization of gender variance:

people are often fearful that their mental health is a barrier and that if they don’t seem like they have their shit together then they can’t actually get care. (Dr. A, general practitioner).

Such concerns may result in a lack of full disclosure to the health care provider. The continued pathologization of gender variance, and the structure of the Canadian health care system produce significant barriers to care for gender variant clients.

5.1.3. Funding

Participants consistently spoke of an across the board lack of financial support for health care for the gender diverse population. This was a significant concern for a wide range of types of care that were felt to be inaccessible due to a lack of competent providers, but also as a result of a lack of funding by the province. These financial barriers are particularly damaging because they are experienced by clients who in many cases are experiencing various forms of discrimination and marginalization, which heightens the difficulty of funding expensive care or access to care. The areas of care emphasized as impacted by financial barriers include:

- mental health care;
- travel costs associated with surgeries not performed in B.C.;
- surgeries and other procedures (ex: facial feminization) not covered by MSP.

Participants noted funding policies that provide varying levels of access to gender-affirming treatments depending on the clinical diagnosis:

...funding of surgery, that's huge: the fact that somebody in – whose identified as.... intersex – if that's identified or diagnosed, then there is no limitation on the amount of surgical reassignment that needs to be done. The government would – it's a different department – they can have all – any surgeries they want, that's become covered by the Medical Services Plan or (the) equivalent across the country, but that's not the case if you are transgender, there's this limited list of four or five things that you are allowed to do...Dr. T: Physician- G.P.).

Participants also identified policies that have unintended negative effects on clients: travel costs to access treatment in different jurisdictions is not covered (an issue of contention in and of itself), but is “available if they are on disability, so it forces people out of work” (Dr. T: Physician- G.P.). Such policies benefit neither the client nor the system as a whole.

Participants noted that the inability to access quality trans- health care puts pressure on other social supports, which underscores the need to improve trans- care options from an economic perspective. As one trans group organizer notes: “(w)e are totally saturated, (which leaves) all these trans folksin really tough positions – taxing the shelter system (for example)” (Justin, Trans- Program coordinator). The funding of health and mental health care support for gender variant people fails to consider the broader context within which care is provided: a lack of accessible support by the health care system will inevitably place strain on another element of society—whether through social insurance or not-for-profit groups—and, consistently, taxes the fiscal, physical, and emotional resources of the patient. The reverse is also true: better accommodation of the needs of the gender diverse population might reduce strain on certain aspects of the health care system.

5.1.4. *Communication and Collaboration*

Difficulty Identifying Providers

Participants noted that difficulty identifying trans-competent providers was a significant barrier to care. Providers noted that it could be challenging to locate other trans-competent providers for support or referrals:

It’s always difficult to figure out what resources to use for what. You want to find a trans friendly plastic surgeon... I know that (inaudible name) is one I usually refer my trans guys to for upper surgery but again, he has very limited surgical time. (Jane, N.P.)

Participants can be considered to be highly motivated and experienced at navigating the health care system with respect to trans- needs, meaning that providers with less experience and potentially less commitment to gender variant clients are likely to be even more “out-at-sea without a life preserver”²⁶ when trying to identify trans-competent providers of a specific discipline. Further, participants acknowledged that difficulty identifying trans-competent providers was also a challenge for gender diverse patients,

26 This quote comes from a family/HIV primary care physician interviewed in Snelgrove et al.’s study on physician side barriers to providing healthcare for transgender patients, who describes the difficulty in “knowing where to go or who to talk to”, which was a major theme in the study.

who often have less understanding of the health care system and less means to navigate it.

Lack of Social Support for Trans- Clients and Allies

Participants were vocal about the importance of social and psychological supports for trans- people, regardless of their interest in or stage of transition. Indeed, as one physician notes:

The pieces that are within the four walls of my office are actually not that (important)...it's just a tiny piece – although a very important piece—of someone's transition. (Dr. T, General Practitioner).

Social support groups specifically for gender diverse clients were consistently acknowledged to be important—as a safe venue for informal peer counselling, sharing coping mechanisms and resources, and simply connecting with other people who can relate to the challenges of being gender diverse in a gender binary society. Ultimately, “transition is a social experience” (Liz, LGBT community worker, trans-program focus). Even providers in the Vancouver core identified a lack of reliable services, despite the importance of clients being able to access support groups. The overall lack of support groups is particularly problematic given the need for a variety of different types of groups, which was strongly underscored by interview participants:

...support groups and chat rooms and all the rest are hugely important.... The challenge is that often support groups tend to have a direction or a flavour. The example that I have is that one of... a couple of my sort of gender queer patients felt a little intimidated by the guys that felt that everybody should be a guy or trans women were overtly women and kind of looked at the... sort of the gender queer in a little bit different way (Dr. D, General Practitioner).

Gender diverse clients have the potential to benefit in a variety of important ways from support groups; however, different clients have different needs, and the same social support group cannot always meet these. Indeed, support groups may play different roles for different people. Practitioners noted difficulty in finding support groups for trans-patients with mental health issues, and particularly those with comorbidities; for some patients, participation in support groups may be difficult or impossible, and medical practitioners may substitute this support.

Social supports are also important for families of trans- people, particularly for trans-youth, whose well-being in part is often dependent upon their guardian's reaction to their gender dysphoria—which may be largely dependent in turn upon the guardian's understanding of gender variance. Where do guardians obtain such knowledge and support? As one participant observes:

...there is a lack of comprehensive services for young people, there's a real lack of support for parents and families – often with young trans folks, the young trans people are fine, they know who they are, they know what they want, it's the parents who are like freaking out, and there is really a lack of support for them, I know very few doctors or nurses who have the skills or the resources or the desire to work with the family as well, which I think is crucial. You have to. (Justin, LGBT worker, Trans program coordination).

Several participants asserted that support groups for families of gender variant youth or adults could be beneficial, and that these are an appropriate and effective venue for parents to obtain the support that they need.

Despite the benefits of support groups, participants noted yet another challenge of relying on them for care. Some communities, particularly rural ones, may have limited numbers of gender diverse people, or those interested in participating in support groups. One practitioner observes that:

The challenge is... can you (run support groups) in Fort St John where there might be one or two... statistically, one or two (gender variant) people in the community. So, the challenge is not as much down here (in Vancouver); it's as you start to get further away (Dr. D, General Practitioner).

6. Policy Objectives and Options

The over-arching objective of this project is to improve health of the gender variant population in B.C. through policies designed to alleviate the range of barriers identified. All the ideas generated through the research are worth exploring in further detail, and have potential to contribute significantly to the objective of improving the health of trans- people in B.C. Many broad-scale ideas were generated as well as local level initiatives; this analysis focuses on the later. However, the broad-scale ideas could well be the most effective in improving access to quality gender affirming health care²⁷. Alongside the main overarching objective are a series of interconnected long-term and short-term objectives necessary to producing tangible change. These include increasing the number of trans-competent providers throughout the province, improving the collaboration and communication between social and medical supports, increasing consideration of social location in programming, and increasing the variety and availability of services provided provincially, such as mental health, primary care, and social support.

A wide variety of suggestions to improve trans- health were identified through the interviews and literature review. The options are not mutually exclusive, and could be implemented independently of each other, or in a variety of combinations. The status quo was considered to be grossly insufficient to meet the health needs of gender diverse clients, a reality underscored by the development of a volunteer clinic in Vancouver “for trans- by trans-“, perceived by both trans- clients and trans-competent providers as necessary to fill the void of quality affirming health care. The status quo fails to provide sufficient levels of quality care for gender diverse population, and involves inefficient usage of already strained resources. While efforts continue throughout the province to

²⁷ Indeed, the Spanish Network for Depathologization of Trans Identities’ *Best Practices Guide to Trans Health Care in the National Health System* emphasizes the need for broad system-wide and socio-cultural changes in order to produce better health outcomes for trans-people—including the need to “re-conceptualize the prevailing medical paradigm” (2012).

improve access to quality trans-competent health care providers, such efforts appear to be largely disconnected, ultimately limiting their effectiveness. The status quo is thus not presented as an option.

Identifying feasible policy options was the priority for this project, therefore the options were first narrowed based on their feasibility. Feasibility was gauged primarily through two factors: the scale of the intervention and the cost. Broad scale interventions that involved significant changes to the structure of the current health care system were streamed out, as were broad scale cultural shifts. High cost options, such as re-instating the Gender Clinic, were often dismissed by the interview participants as 'dreams', and were rarely discussed in the interviews; thus, policy ideas were eliminated from the analysis based on cost concerns. Further, interview participants emphasized the effectiveness of low cost options, asserting that a minimal increase in dedicated resources could produce notable positive change. The remaining options are those that were discussed frequently throughout the interviews, and/or with great support and enthusiasm from participants; they register on the lower end of the cost curve, and are considered to be the most feasible of the policy ideas generated. They also consider the impact of intersecting social locations and how these affect the experiences of gender diverse clients, seeking to expand recognition of this important facet of experience. The ideas selected for further analysis and policy development focus largely on increasing provider education and opportunities for communication and collaboration. Specifically, the policy options presented are: a mentorship program involving a province-wide, bi-weekly mentorship phone call and a centralized mentoring list; a trans-focused web-site with information and contacts for both providers and patients; and enhanced mental health supports for gender diverse clients. For a summary of the policy approaches suggested by interview participants, see Appendix C.

6.1. Mentorship Program

Numerous participants highlighted the importance of mentorship as a central element in increasing the number of trans-competent providers, and advancing the knowledge of practitioners currently providing some component of trans- care. Mentorship was seen to provide benefits not experienced through training. Specifically, it

allowed for ongoing support related to specific cases or types of care, and provided practical, less formal advice about navigating the health care system with respect to trans- care, which is particularly important given the systemic barriers identified. This dynamic can allow learned information about complex health care issues, such as the impacts of intersecting social locations, to be shared by experienced providers. Not only can mentoring provide practitioners new to trans-health with tangible information, but it also ensures that practitioners have the ability to consult with experienced providers of trans- health care should they so desire. As expressed by one practitioner, this may make all the difference:

I think that's ideally the way to go because often if people know that they have someone they can fall back on or they're sharing the responsibility with that person and they're going to be more willing to kind of do some care that otherwise they would feel nervous about. (A)nd also....if you provide written instructions about... -"this is the monitoring that I would do... This is the kind of dose range that we usually use for testosterone." - You know just a little bit of basic information that can help them to feel just a lot more confident about what they are doing. (Dr. M, General Practitioner).

The need to support trans- care providers is also found in the literature. Raj's exploration of how to provide "trans positive" therapy identifies a need for both "encouragement and support for the emergent stream of TS/TG mental health and sexual health providers", as well as "ongoing training and professional development for both mental health and sexual health practitioners" (2002). Mentorship could benefit professionals from all levels and types of health care, including mental health. This policy option reflects the intersectionality framework by enabling opportunities for practitioners to connect, share information, and develop their abilities to provide care for a range of intersectional identities. Information about how to provide quality gender-affirming care for a range of diverse clients, who may also be part of other potentially marginalized identities, may be particularly difficult to obtain in a formalized classroom setting or through an academic context. However, experienced trans-competent health practitioners have developed first hand knowledge about how best to support such clients, which heightens the importance of having a mechanism through which inexperienced providers can access such knowledge. The complex interactions of intersectional identities may be better able to be addressed in a context of communication and collaboration. Two main opportunities to

enhance mentorship were noted by participants: a mentorship phone call, and a mentoring list.

6.1.1. *Mentorship Phone Call*

This method was seen as particularly useful in connecting practitioners in different regions. A weekly mentorship call is currently held in Ontario and is considered to be a very successful “community of practice”. The mentorship call was well received among B.C. interview participants:

I went “oh, conference calls, brilliant idea!” ...It’s just a no-brainer. I was like “oh, perfect. Let’s do that.” (Dr. M, Clinical Psychologist).

In B.C., the call could be hosted regularly (weekly/by-weekly) by a trans-competent practitioner or community worker. It offers an extremely low barrier method of identifying other trans-competent or trans-friendly practitioners, and allows practitioners to both expand their knowledge and gain support regard challenging cases, but allows enables practitioners to identify trans-competent providers in different areas medically and geographically. Such “cross pollination” was emphasized as important during the interviews, and Raj “strongly urged... the affiliation of trans- and non trans-identified mental health providers and sexual health providers” with eachother (2002). Practitioners could be informed about the call through the Transgender Health Program— both physical and online locations—as well as through community health centres, and LGBT community and out-reach groups province wide.

6.1.2. *Mentoring List*

Casual mentorship occurs naturally within the community health centres. Though practitioners highlighted the benefits of in-person mentorship, such relationships were acknowledged to occur largely through coincidence, dependent on whether trans-competent providers worked in proximity to providers interested in or open to developing or expanding their knowledge about gender-affirming health care. Given the significant benefits of mentorship, a more deliberate process might increase the number of mentorship relationships and thus ultimately increase the number of trans-competent providers. The main barrier to increased mentorship appears to be simply identifying and

matching interested parties. Currently, the Transgender Health Program provides a triage function for patient calls looking for a point of access for primary care. The THP could also be used as a triage location for providers to identify trans-competent practitioners interested in sharing their knowledge. Providers could request their name and contact information be added to a list or database, and then these names could be released to providers looking to access support with providing trans- care. While this option might be most accessed by local providers who would hear about it through community health centers, as with the mentorship phone call, practitioners could be informed about the mentorship list through the Transgender Health Program— both physical and online locations—as well as through community health centres, and LGBT community and out-reach groups province wide. Depending on the comfort level of providers involved, a list of trans-competent providers could be housed through a community website.

6.2. Trans-Focused Website

A website focusing on the health and wellness of the gender diverse population would provide a number of important, interconnected services necessary to improve access to gender-affirming health care in B.C. This option can easily be implemented in stages and can grow to reflect the needs and capacities of the community and stakeholders. A provincially based website could provide a variety of functions to both patients and health care providers. The need for such a website has been articulated by a number of other studies, including the Kopala Report (2002) and the Ontario Public Health Association's Trans Health Project (2003). For practitioners, it could provide access to the variety of care guidelines available. It could house a central list of providers who identify themselves as trans-competent, primary care providers, specialists, and mental health providers. This would help improve communication between providers in different disciplines and locations, improving their ability to refer across disciplines and to coordinate care between cities. This list could either be made accessible to the public through the website, or could be made accessible only to providers who had registered and received a password. Providers with valid emails through a health authority could register easily online, and providers not affiliated with a health authority could request a password through the website. The website opens up a

variety of opportunities, which could be explored based on the amount of funding available. Increasing mentorship opportunities is one such potential. The website could also provide a forum for mentoring which would be very accessible and likely generate more participants than the happenstance mentoring that occurs within community health centres. The provider focused, password protected element of the website could offer a discussion board for practitioners looking to access or provide support for providers of trans-care to identify themselves, and connect with other providers.

For patients, the website would also provide information about gender diversity, and discuss health issues and processes of interest to gender variant clients. It could provide an interactive component, where clients could recommend services or events, and or generally provide or receive support; this can help combat the severe isolation noted in the Vancouver Island Trans-Needs Assessment (VITNA), where half the respondents felt socially isolated most or all of other time, and an additional 22% felt isolated some of the time (2012). The website provides an opportunity for gender diverse people to share their knowledge and experiences, “expanding what is typically constituted as “evidence”, and reflects an Intersectionality-Based Policy Approach (Hankivsky et al., 2012). It further enables gender diverse clients to draw attention to the diverse experiences of their population, and the impact of social locations on these experiences. Dewey emphasizes the importance of this process, noting that trans-people:

‘work’ to make previously exclusive medical knowledge more accessible. They acquire this information through interaction with each other and the Internet, and use this knowledge to push for particular treatment not normally granted to them. Hence, through their “work,” trans-patients can introduce to doctors fresh perspectives about treating trans-people. Such ideas might develop into renegotiations among the medical community that could ultimately legitimize a new form of knowledge (2008).

This is the only option that directly incorporates diverse knowledges, and specifically enables trans- people to actively participate in health discourse in order to counter the trend pathologizing of gender variance, the importance of which is also articulated in the VITNA (2012) and by Greatheart (2010).

The website could also provide a central area for a list²⁸ of community based support groups, and facilitate communication and collaboration between them. Peer-based supports are seen as crucial to improving the care environment for gender diverse clients, as one participant notes:

(b)asically to get things done in health care – in the world actually and in health care particularly, you need three things: you need a professional organization, you need a peer community organization, and you need an advocacy organization. And we only have two, we don't have the community (organization), and the three work in concert to get things done. (Dr. T, General Practitioner).

Ensuring that all the available services, with up to date information, are readily identifiable by the public is essential to ensure that the services are accessible to those who need them. A website could ensure that each community group had access to their own page, so that they could easily update changes in service provision. The website can be structured so that updating a page can consist of logging in and posting a comment, and not involve any specific technical knowledge.

Ensuring that interested parties would be aware of the website could be achieved through advertisement undertaken in the similar fashion as with the mentorship program—sharing the information through the THP, community health centres and community LGBT groups via posters and word of mouth.

6.3. Mental Health Supports

This intervention would address the lack of mental health services for transgender people. Both the Mentoring program and the Trans-focused website provide opportunities for mental health providers to locate trans-competent professionals and relevant information, but this option specifically focuses on increasing access to quality, trans-competent mental health care. Throughout the interviews, mental health services were identified as a crucial but largely absent piece of the care puzzle for transgender

²⁸Currently, there are a variety of such lists available, housed through community or advocacy groups, but these tend to be decentralized, and are often in non-electronic form. Thus, they are difficult to update, particularly for small, highly in demand providers, and important information such as time and location of social support groups quickly becomes stale.

health. Without increased access to mental health services, other developments in accessibility to gender-affirming health care may not be able to be as effective. Mental health care needs to go hand in hand with primary care, in order to ensure that interventions have the most positive and lasting effects. The Vancouver Island Trans-Needs-Assessment found that the most required but currently not accessible mental health services were councillors/social workers and support groups²⁹ (2012). By focusing specifically on improving mental health supports, this option acknowledges and supports the complex needs of gender diverse clients, which may develop as a result of inhabiting intersecting social locations and challenging oppressive power structures, and thus reflects an IBPA approach.

Given the severe funding restraints, this option would build on the central structure of the Transgender Health Program (THP). One additional staff member would be hired to work within the THP: a councillor with experience in gender diversity issues. This team member would act as a liaison between gender diverse clients, community groups and the formal medical system. Positioned at the intersections of these groups, they would thus be able to connect clients with a wide range of mental health support systems, with the broader goal of developing an accessible community of support. This team member would provide several functions, and would be involved in both education and outreach initiatives, as well as care provision. The councillor would work to identify current trans- competent mental health care providers, and build a recognized network of knowledgeable mental health providers, with an emphasis on identifying providers with sliding scale payment mechanism. They would liaise with community groups that offer low cost or cost free counselling, and those that provide social and mental health groups, developing detailed knowledge of the nature of the groups, in order to help trans- clients to identify the most appropriate group and therefore increasing their chance of finding appropriate support. The councillor would further seek to identify mental health care providers open to learning about gender diversity through community and health care connections. They would also provide both general education and specialized training about gender diversity in a mental health context to interested

29 Counsellors/social workers and support groups were indicated as required for reasons both related and un-related to gender identity; for reasons related to gender identity psychologists were also needed

providers and organizations. Finally, the councillor would provide some one on one mental health counselling, as well as run support groups for various groups of gender diverse patients. This option would be easy to scale up or scale back depending on funding, by adjusting the hours of the councillor, or exploring cost-sharing options with different branches of the health authority or community groups.

7. Criteria and Measures

Criteria and measures were developed to help evaluate the policy options identified: a mentorship program, a trans-focused website, and enhanced mental health supports. The criteria and measures are first presented in brief in Table 1, followed by more detailed description.

Table 1: Summary of Criteria and Measures

Criteria	Definition	Measure
Effectiveness		
<i>Outcome improvement</i>	The intervention's ability to improve outcomes as a result of increases in provider knowledge and access to trans-competent providers.	1= Low improvement in outcomes 2= Moderate improvement in outcomes 3= High improvement in outcomes
<i>Equitable distribution of outcomes</i>	The intervention's ability to increase equitable distribution of outcomes throughout the province and between various groups of gender diverse clients.	1= Low increase in equitable distribution of outcomes 2= Moderate increase in equitable distribution of outcomes. 3= High increase equitable distribution of outcomes
Cost		
<i>Implementation</i>	Financial resources necessary to establish the intervention relative to the status quo and other options.	1 = < \$2, 000 2 = \$2,001 - \$15,000 3 = \$15, 001 +
<i>Operating</i>	Financial resources necessary to maintain the intervention relative to the status quo and other options.	1 = < \$2,000 2 = \$2,001 - \$15, 000 3 = \$15, 001 +
Acceptability		
<i>Political/Public acceptability</i>	The extent to which the intervention is likely to be accepted politically; this is largely based on the anticipated public response	1 = Low acceptability 2 = Moderate acceptability 3 = High acceptability
<i>Health care community</i>	The extent to which the intervention is likely to be accepted by the health care community.	1 = Low acceptability 2 = Moderate acceptability 3 = High acceptability

Criteria	Definition	Measure
<i>Trans- groups</i>	The extent to which the intervention is likely to be accepted by LGBT community groups and trans-groups.	1 = Low acceptability 2 =Moderate acceptability 3 = High acceptability

7.1. Cost

Cost is a primary concern for trans- health care initiatives in B.C. Indeed, the cost of programs has been the deciding factor for the closure of specific programs in this area previously—the Gender Clinic was closed 10 years ago due to a lack of funds. Thus, in a time and field of fiscal restraint, cost is the central determinant for the feasibility of the project. Ideally, this criterion would take into consideration the fact that insufficient access to gender affirming care presents other costs to society, through the increased marginalization of trans- people and the deterioration of their health and wellbeing, costs as a result of increased utilization of employment insurance, increased use of shelters, and decreased participation in the labour market (among others). However, there remains a lack of data about the additional costs to society as a result of inadequate trans- health care. Data on private costs to individuals are also not available, and thus these two important elements are not evaluated. Only the costs of the interventions are evaluated. The costs are assessed relative to each other and the status quo, given that costs for the options are difficult to determine and thus subject to debate.

7.1.1. *Implementation*

This criterion captures the cost of the intervention to implement, which is borne in most cases by the government at some level, whether this is the health authority, or the province. Implementation costs will depend on the complexity of the intervention and whether it involves the creation of a new formal program or simply entails informal amendments to an existing project. Implementation costs of the options are assessed relative to each other.

7.1.2. *Maintenance*

This criterion captures costs required to maintain the policy once implemented. This measure incorporates some sense of the financial sustainability of the intervention, which is a vital consideration for the feasibility of the project. Initiatives with high maintenance costs may be particularly infeasible given the fiscal climate and the fact that interest in new initiatives, especially those benefiting often marginalized minority groups, tends to wane over time; for example, the Gender Clinic was not maintained after 10 years due to perceived budgetary restraints.

7.2. Effectiveness

The current level and nature of health care services accessible to gender diverse people in B.C. is clearly failing to meet the needs of this population, a fact that was emphasized throughout the interviews and supported by the literature review. Assessing the effectiveness of the policy options is thus central to determining whether the options can improve the current situation. Given that this project seeks to increase the fairness of access to appropriate, quality health care, an intervention's effectiveness will be determined by two sub-criteria: the ability of the intervention to improve outcomes, and the ability to distribute the benefits throughout the population.

7.2.1. *Outcome Improvement*

This criterion captures the intervention's ability to improve outcomes as a result of increases in both provider knowledge and access to providers. A lack of knowledge about gender variance is at the core of the lack of trans-competent providers and policies. Thus, increasing the number of trans-friendly and trans-competent health care providers was overwhelmingly identified as crucial to improving health outcomes of gender diverse patients. The effectiveness of the intervention to improve knowledge of providers will in part be determined by whether the intervention has an "out-reach element". Active attempts to provide more information are presumed to be more effective in reaching providers than the passive presentation of information that requires providers

to be active in seeking it out, in which case the information is likely to be less frequently utilized.

An intervention's effectiveness is also largely contingent on access to providers; the technical existence of trans-competent providers is only one factor, and almost irrelevant if providers cannot be accessed by clients in need. Increases in access could occur through increased ability to identify and locate trans-competent providers, a decrease in the centralization of providers, or decreased gate-keeping practises.

7.2.2. *Equitable Distribution of Outcomes*

This sub-criterion addresses equity, and captures the extent to which the intervention benefits all members of the gender diverse population equally. To this end, distribution of outcomes is assessed through both the intervention's ability to provide equitable access to providers, and the ability to provide equitable quality of care. The project focuses on provider side solutions; therefore, the benefits to gender diverse clients are largely a result of mitigating the effects of provider side barriers. However, some of the options have elements that affect clients directly. Both direct effects and those as a result of provider-focused interventions are taken into consideration when gauging the distribution of benefits among gender diverse clients.

Equity of access reflects the ability of the intervention to be accessed by all members of the gender diverse population. Two considerations are key: provider's ability to benefit from the intervention, as well as the level of access to the intervention by the gender diverse client (if the intervention has a direct client component). The issue of geography is immensely important in B.C, as under the status quo trans-competent providers are overwhelmingly concentrated in Vancouver.

Equity of quality care reflects the interventions' ability to distribute outcomes across the range of gender diverse patients with different needs. The importance of recognizing and addressing the diverse and different needs *within* the gender variant population is particularly emphasized given the intersectionality framework. In order to provide quality care for the individual, health care provision needs to reflect the different ways of being trans-, in order to avoid privileging certain gender diverse identities or

manifestations of identities. Equity of quality care also involves the intersectionality of marginalized identities; individuals who exist in multiple areas of social and institutional exclusion (ex: trans- people who are disabled, of ethnic minorities, or of low socio-economic status) are uniquely affected by policies and may be dually discriminated against by policies and people. This sub-criteria measures the ability of the intervention to improve the quality of care received by all members of the gender diverse community, reflective of their concurrent and interrelated needs as members of other identity groups.

7.3 Acceptability

This criterion measures the extent to which the intervention is likely to be accepted by the various stakeholders, as support—or at least a lack of dissent—from these parties is crucial for implementation. The response of these stakeholders to the policy options is evaluated in the context of the current political, social, and economic environment.

7.2.3. *Political/Public*

This sub-criterion captures the likelihood of political and public acceptance, which is crucial to the feasibility and success of the intervention, as the allocation of limited funding tends to be sensitive to public opinion. The level of acceptability by these stakeholders is very intertwined; political response to the intervention is liable to be based largely in part on the perception of public acceptability. A continued lack of education about gender variance, coupled with lingering transphobia, means that the public is likely to be ill-educated about the needs of the gender diverse, and thus particularly sensitive to the cost component of trans-focused interventions. Thus, low cost interventions that do not involve significant system changes or are not particularly visible to the public eye are most likely to be accepted by the public.

7.2.4. *Healthcare Community*

This sub-criterion captures the likelihood of support from the health care community; the support of the health care community is vital as interventions will affect this community directly. The support from this group will be necessary in order to both demonstrate

feasibility, and achieve success in implementation. Healthcare community stakeholders include providers and administrators who are involved in providing front-line care to patients in B.C., and are stakeholders who are less likely to be mainly governed by political considerations, and whose interests are rooted in health care effectiveness. The acceptability of interventions to the health care community will be gauged based on the intervention's ability to increase the ability of providers to provide quality of care, the potential for the intervention to enhance the provision of care in other areas, balanced against the degree of disruption to provider's schedules and work environments, the likelihood of the intervention to co-opt other health care resources, and compromise the standard of care to other marginalized groups.

7.2.5. *Gender Diverse Clients and Organizations*

This sub-criterion captures the likelihood of support from gender-diverse clients and organizations representing them. Support from trans- people is central to the feasibility of initiating and long-term success of the policy options, given that this is the target population expected to benefit from the interventions. The degree of acceptability of the policies to trans- groups are gauged by the responses of the trans- providers interviewed, information gleaned from trans-activism literature, and the stated goals and priorities of provincial LGBT community groups.

8. Assessing the Options

The policy options were assessed through the criteria and measures previously outlined. The following table summarizes the evaluation results, which are then discussed in detail.

Table 2: Evaluation Summary

	Mentorship	Website	Mental Health
Cost	3	2.5	1.5
Implementation	Low (3)	Moderate (2)	Moderate (2)
Maintenance	Low (3)	Low (3)	High (1)
Effectiveness	2.5	2.75	1.5
Outcome improvement	Moderate (2.5)	Moderate (2.5)	Moderate (1.75)
Equitable distribution of outcomes	Moderate (2.5)	High (3)	Low (1.25)
Acceptability	2.7	3	2.3
Political/Public	High (3)	High (2.5)	Moderate (2)
Healthcare community	High (3)	High (3)	Moderate (2)
Trans- groups	Moderate (2)	High (3)	High (3)
Totals (max 9)	8.2	8.25	5.3

8.1. Mentorship Program

8.1.1. Cost

The overall cost of establishing and maintaining a mentorship program featuring both a mentorship list and a mentorship call is anticipated to be in the low cost range compared to the status quo, ranking a 3 (where lower cost is preferable, so lower costs yield a higher score).

Implementation

Implementation costs are predicted to be relatively low, and rank a 3 on the scale. For the mentorship list, implementation costs would be limited to the gathering of names of providers interested, which is an ongoing process informed by community members, and could be easily initiated through a small number of brief phone calls to key providers. Follow up with individual providers to ensure their interest in acting as a mentor would also be necessary but could be accomplished through several mechanisms: through phone calls, email, or through discussions with directors of community health centers, who could help contact all trans-competent physicians in the clinic. Brief training of the VCH triage person would also be necessary, but no additional hiring would be required. Informing stakeholders about this new resource is also important, and would occur through the community health centres, and local LGBT groups who could pass along the information to their provincial contacts. Costs for developing the mentorship list would likely be limited to 30 hours of labour by a community member, under \$1000. Implementation costs for the mentorship call include identifying an individual to run the call, and potential training. Hiring costs and training are estimated to be low, particularly if the hiring is done through community groups and current THP staff. As with the mentorship list, informing stakeholders about this new resource is crucial, and would occur through the community health centres who could share it with and local LGBT groups who could pass along the information to their provincial contacts. Total implementation costs of the mentorship program are anticipated to be under \$1500.

Maintenance

Maintenance costs are also low, and rank a 3 on the scale. With respect to the mentorship list, providers would be responsible for removing their names from the list if they were no longer interested or able to provide mentorship. The list should also be maintained to ensure that it is still useful, likely biannually, to ensure that practitioners are still providing trans- health care. These costs will be minimal, likely 5-10 hours every other year, under \$300. With respect to the mentorship call, ongoing costs will be limited to the wages of the person running the mentorship call estimated at \$2000 per year, given a bi-monthly, one hour call. Physical space and access to a phone can likely be secured through a community group or the THP. Ongoing maintenance costs of the mentorship program are anticipated to be under \$2150 per year.

8.1.2. Effectiveness

The Mentorship program would be highly effective, and ranks a 2.5 on the effectiveness scale.

Outcome Improvement

The initiative has a high capacity to improve outcomes as a result of increases in provider knowledge and increased access to trans-competent providers. It provides a mechanism to access one on one support for providers new to trans-care, as well as a way to touch base, practically, for providers all over the province. Particularly, it enables access to informal advice about navigating the system and practical care advice. The mentorship program also enables physicians to better access support for trans-health care, which indirectly increases access to gender-affirming care for clients. Both the Mentorship call and list initiatives are specifically structured to enable providers outside Vancouver and the lower mainland to participate, and are actively promoted outside the lower mainland. This is likely to increase the ability of providers outside the core who have fewer resources, meaning that patients in these regions have better access to practitioners comfortable providing care. Further, patients having difficulty accessing care rurally may better be able to do so if they can direct a potential primary caregiver to more experienced providers.

The nature of the information shared through the mentorship program will depend on the knowledge of the mentors and the demands of the providers looking for support. The Mentorship program is limited in its effectiveness because providers who are very removed from trans- health care, arguably those who would benefit most from the mentorship, are less likely to learn about and thus utilize the program. However, the initiative includes advertisement, through the THP, community health centers and community LBGT groups that actively informs practitioners about the possibility of support in trans-care, and this may help reach a broader group of practitioners. This option ranks a 2.5 in terms of the outcome improvement component of effectiveness.

Equitable Distribution of Outcomes

The mentorship program is also highly effective due to its equitable distribution of outcomes. The mentorship program actively encourages physicians outside the core

care area to expand their knowledge of trans- care and provides practical, effective mechanisms by which to do so, working to ensure that access to quality care is equitable across the province. By enabling experienced trans-competent physicians to share their expertise with less experienced physicians, many issues of care—such as the effect of intersectional marginalities—can be better addressed. Mentoring with experienced physicians might also help alleviate the pathologization of gender diversity, which is associated with care provision that over-emphasizes transitioning. Providing support to inexperienced physicians interested in working with trans- clients may increase the number of physicians who can provide gender-affirming health care, thereby increasing access by growing the pool of trans-competent providers. The mentorship call ensures that providers throughout the province can participate in ongoing discussions with other providers, and the mentorship list enables providers to access one on one support from a distance. This option ranks a 2.5 with respect to an equitable distribution of outcomes.

8.1.3. *Acceptability*

The Mentorship program has overall high acceptability, ranking a 2.7.

Political/Public

The Mentorship program is anticipated to have high public and political acceptability, largely due to the low cost of the program. Further, the program will likely exist outside the purview of most citizens who are not actively involved in trans- work, and is therefore unlikely to provoke disapproval. Physician education is not a particularly controversial issue. This option ranks a 3 in terms of public acceptability.

Healthcare Community

The Mentorship program is expected to be actively welcomed within the medical community. Practitioners involved in providing trans-care are expected to be extremely supportive, given that the importance of mentorship and interest in acting as mentors were strongly emphasized throughout the interviews. Practitioners not involved in trans-care are unlikely to protest the program, as it involves minimal resources and only requires voluntary involvement. This option ranks a 3 in terms of health care community acceptability.

Trans- Groups

The Mentorship program is expected to be moderately well supported by LGBT and trans- groups, as well as on the individual level. The intervention addresses the core lack of trans-competent practitioners and seeks to address the concentration of care in Vancouver. However, support might be more limited relative to the other interventions because the mentorship program does not provide direct or immediate support for the gender diverse. This option ranks a 2 in terms of trans-group acceptability.

8.2. Trans Focused Website

8.2.1. Cost

The overall cost of establishing and maintaining a website focused on gender diversity and health and wellbeing is anticipated to be in the high cost range compared to the status quo, ranking a 1.5 (where lower cost is preferable, so lower costs yield a higher score).

Implementation

Implementation costs are expected to be high, ranking a 1 on the cost scale³⁰. The implementation costs are largely contingent upon the cost of the website design, which varies depending on the cost structure of the website designer hired. The lowest estimate range for a website with the features described is estimated at \$4,822 to \$6,400, when an offshore contractor is used, \$9,973 to \$13,306 where a freelancer is used, and \$19,417 to \$26, 083 when a professional firm is utilized. The mid-point of the middle cost range is \$11, 640. The cost estimation process can be found in more detail in Appendix D. Implementation costs for the website are taken to be roughly \$12,000.

³⁰ The cost estimations were generated through the DesignQuote website, which provides customized cost estimations for websites based on specified features, and connects clients with designers.

Maintenance

Maintenance costs are anticipated to be quite low, ranking a 3 on the cost scale relative to the status quo. The implementation costs include the software for content generation and editing, so updating the website will involve only labour costs, hosting costs (\$120/year) and the cost for the domain name (\$10/year). Assuming only a 10 hours a year of website content editing are required, maintenance costs will be around \$400 per year.

8.2.2. *Effectiveness*

A trans-focused website would be highly effective, as it directly addresses the central need for increased knowledge about and access to trans- health care. It is unique in that it provides direct benefits to both providers and gender diverse clients. This option ranks a 2.75 on the effectiveness scale.

Outcome Improvement

A trans-focused website improves outcomes through the provision of a wide range of accurate, up to date information, providing both practitioners and clients with a centralized location to gain a wide range of information about health care for the gender diverse. This might increase the perception of legitimacy of the information, and thus increase the comfort level of users in relying upon this information—whether this means providing hormone therapy or contacting a provider. Further, this option is the only option that provides space for patient knowledge to be disseminated. Enabling sharing of patient's lived experiences and healing processes can deepen the knowledge of trans-health, and increasing communication between and among both providers and patients expands the pool of resources.

This option also provides a mechanism for both providers and practitioners to identify and connect with experienced providers, thus increasing both the breadth of knowledge accessible and also the access to providers. This option presents a low barrier approach to accessing physicians, and may also decrease the gate-keeping dynamic that inhibits patient access. Information about the website is also actively disseminated through community health centres, LGBT groups, and the THP, increasing

the awareness of potential users of the ready availability of support and information, and thus increasing the likelihood of utilizing the resources.

Equitable Distribution of Outcomes

The website would enable providers and gender diverse clients to connect with both each other, and their respective peers; it is particularly beneficial to those who are geographically isolated. The direct benefits of this option are only available to gender diverse clients who have access to the internet, which may exclude clients with limited economic means and those in rural areas where internet access is more uncommon, expensive, and unreliable. The trans-focused website also fosters education about different types of gender diverse identities and associated health issues through the provision of information online, and ideally through mentorship as well. Enabling mentorship opportunities may produce better understanding and thus care for gender diverse clients, including those who face other challenges in accessing appropriate quality health care. This option ranks a 3 in terms of the equitable distribution element of effectiveness.

8.2.3. *Acceptability*

Political/Public

The trans-focused website is anticipated to have relatively high political and public acceptability, ranking a 2.5. Information sharing initiatives are generally well received by the public. The existence of the initiative is unlikely to permeate the broad public consciousness, and therefore segments of the public that might be opposed to spending money on a trans-focused website are unlikely to encounter the website. The political and public acceptability of the program might be diminished based on the increased cost to the health care system compared to the status quo.

Healthcare Community

The trans-focused website is anticipated to have high acceptability within the health care community, ranking a 3. Practitioners involved in providing trans-care are expected to be extremely supportive, given that the website directly addresses one of the main needs identified in the interviews: the increased ability to identify and locate

providers. Practitioners not involved in trans-care are unlikely to protest the program, as it provides resources they might one day need to utilize.

Trans- Groups

The trans-focused website is anticipated to have high acceptability by trans-groups, ranking a 3. It provides direct support to gender diverse clients, as well as enabling practitioners to develop their knowledge about gender diversity and health. Further, it connects community groups, health professional, and clients.

8.3. Mental Health Supports

8.3.1. Cost

The overall cost of establishing and maintaining mental health supports is anticipated to be in the high cost range compared to the status quo, ranking a 1.5 (where lower cost is preferable, so lower costs yield a higher score).

Implementation

Implementation costs are expected to be low, ranking a 3 on the cost scale. Costs would include hiring an additional team member, as well as training or orientation within B.C's health care system and community groups. Finding the right individual for the role of counsellor housed within the THP would be crucial to the success of the initiative.

Maintenance

Maintenance costs are anticipated to be high, ranking a 1 on the cost scale relative to the status quo. Costs of increased mental health supports would include the salary of a part time counsellor. Given a 30-hour workweek, at an anticipated wage of \$25 per hour, the labour costs will be around \$36,000 per year.

8.3.2. Effectiveness

Providing mental health supports through this option would be moderately effective at improving the overall health and well-being of gender diverse clients. This option ranks a 1.5 on the effectiveness scale.

Outcome Improvement

Increased mental health supports provide both practitioners and clients with a centralized location to gain information about mental health care for the gender diverse. This option provides immediate direct mental health care to gender diverse clients, and provides health care practitioners with more information about trans- mental health care and where else to refer to for care. The intervention has good potential to improve outcomes as a result of increases in provider knowledge about both service availability and care provision. However, mental health is only one element of health care, and this option does not provide for the needs of clients who do not need to utilize these services. Increasing mental health supports through this option would provide accessible mental health care services to gender diverse clients in the Vancouver area. However, the effectiveness of the option would primarily benefit clients in the lower mainland, as there is no specific component to address rural need. This option ranks a 2 with respect to the outcome improvement component of effectiveness

Equitable Distribution of Outcomes

Access to mental health supports in Vancouver will be significantly improved by this option, but the benefits of the program will be very geographically limited, meaning that a significant portion of B.C. residents would not be able to access the direct benefits of the program. Further, improvements in quality of health care through this intervention are limited to mental health care, which, while identified as an important but lacking component of current health care provision, is only one component of health. Thus, gender diverse clients seeking health care but who do not require mental health care services will not benefit from this program. Mental health care may be particularly beneficial for gender diverse clients who occupy other marginalized identities or face other challenges. This option ranks a 1.25 with respect to the equitable distribution of outcomes.

8.3.3. *Acceptability*

Political/Public

Increasing mental health supports through this option is anticipated to have moderate levels of public acceptability, ranking a 2 relative to the status quo.

The existence of the initiative is unlikely to permeate the broad public consciousness, and therefore segments of the public that might be opposed to spending money on trans-focused mental health support are unlikely to encounter the initiative. However, stigma around both mental health challenges and gender diversity continues, and these continued social biases may affect the public acceptability of the program. The public acceptability of the program might be further diminished as a result of the increased cost to the health care system compared to the status quo.

Healthcare Community

Increasing mental health supports through this option is anticipated to have relatively high levels of acceptability within the health care community, ranking a 2.5 relative to the status quo. Practitioners involved in providing trans-care are expected to be extremely supportive, given that increased mental health supports were highlighted as a vitally required service. The importance of mental health to overall wellbeing is increasing being recognized. However, the high maintenance costs of providing mental health supports to gender diverse clients may decrease support in a segment of the health care community, where finances are extremely tight and minorities groups and mental health largely remain secondary considerations.

Trans- Groups

Increasing mental health supports through this option is anticipated to have high acceptability by trans-groups, as mental health services have consistently been identified as a priority need by gender diverse clients; therefore, this option ranks a 3. It provides direct mental health support to gender diverse clients, and connects clients with community supports.

8.4. Recommendation

The interviews and evaluation emphasized that the barriers to both accessing and providing gender-affirming health care are significant, and unlikely to be effectively addressed through any single option. There is a clear need for increased education, better collaboration, and enhanced information provision. Therefore, the Mentorship program and the Trans-focused website are both recommended to be pursued as short-term policy options. These two options can be implemented in a complementary fashion, where the website is used to facilitate mentorship opportunities, and works as mechanism to advertise the mentorship call. This policy suite is likely to be both highly effective and financially sustainable, as both options require extremely minimal maintenance funding, and have moderately low implementation costs.

This suite utilizes the existing care framework, and focuses on harnessing the current available resources and facilitating more effective employment. These options work to address the main policy objective of improving the health and well-being of the gender variant population in B.C. in a number of ways. The use of the Internet, with its lower barrier to access, potential to reach a wide audience, and opportunities for interactivity, is an important step in developing an environment conducive to prioritizing gender-affirming health care. The trans-focused website centralizes and increases the availability of reliable, quality information about trans-health resources and issues for both providers and clients. It provides space for gender diverse patients to give and receive support, incorporating their knowledge and enabling it to be shared with other patients as well as providers. The website also facilitates mentorship opportunities, providing another point of entry for participants, and one particularly viable for rural participants.

The mentorship call provides a new mechanism for collaboration and communication between practitioners. The mentorship call also emphasizes the use of technology in order to ensure providers outside of the Vancouver core have an opportunity to participate in and benefit from the initiative. Both the mentorship call and

list increase the opportunities for a range of practitioners to develop trans- health knowledge in an effort in increase the number of trans-competent providers.

In the long run, when additional financial support for additional initiatives is identified, trans-competent supports for mental health must be developed. Mental health care is a glaring gap in the current care structure. The option evaluated in this project represents the bare minimum of the action that needs to be taken on this front. Without access to quality mental health support through trans-competent providers, the ability of trans-clients to achieve full physical and mental health is significantly diminished, and the efforts of all initiatives may be stymied.

9. Discussion

9.1. Limitations

Several factors limit the ability of this study to develop effective policy options to address barriers to gender affirming care in British Columbia. The limited number of interviews conducted, the use of snowball sampling, and the high concentration of urban health professionals means that the results may privilege the opinions of a specific group of people, and may not reflect barriers throughout B.C. Further, interviewing only health and health related professionals creates two gaps in data: the experiences of gender variant clients themselves with barriers to accessing gender affirming health care, and the perspectives of government, both bureaucrats and politicians. All study participants had extensive direct contact with gender diverse clients or identified as trans-themselves, and were actively engaged in improving the health and well-being of the gender diverse population through a variety of levers. In addition, the professional “insider” status of the participants meant that they were able to identify and deconstruct structural barriers clearly. Thus, despite often being cis-gendered, participants were able to effectively communicate barriers to gender-affirming health care from an informed location. The lack of access to the political perspective and context of trans- health issues severely diminishes the ability of gauging political feasibility, which is central to the development of effective policy options. Lack of access to bureaucrats with knowledge about the process and criteria utilized in funding decisions for trans- health issues—such as the Gender Clinic and coverage of SRS surgeries—obscures decision-making details that are important to an understanding of the broader health care context, as well as the development of feasible policy options to address insufficient access to gender-affirming care. Despite its limitations, this study illuminates alleviating provider-side barriers as an important policy lever to improving the health of gender diverse clients. By stimulating dialogue about barriers to trans-care among a range of experienced, trans-competent front-line workers, this project provides feasible

mechanisms to better support trans-competent practitioners, and by extension improve the health outcomes of gender diverse clients. It further opens the door for increased collaboration between front-line workers from different disciplines and organizations, policy-makers, and gender diverse clients.

9.2. Furthering the Discussion

Discussion about how to improve the care availability and environment for gender diverse clients in B.C. has intensified within the past 10 years, following the closure of the Gender Clinic. Nationally, efforts to identify the needs of gender variant people, and to recognize and respect their voices, have made important steps towards developing and realizing policies that meet—or better meet—the serious gaps in gender-affirming health care. However, policies that harness the slowly growing body of research are in early stages; for example, many of the policies recommended in 2002 by the Koopla report have yet to be realized. Examinations of barriers to providing gender affirming care have largely focused on the patient side; given that patients tend to have less experience with the inner-workings of the health care system, this approach, while clearly very important, may not produce policy driven solutions. Exploration of barriers on the provider side has been limited and focused on the experiences of a broad range of physicians, including those who have no experience providing care to gender variant clients.

This study advances the current understanding of provider side-barriers to gender-affirming health care, by employing in-depth qualitative research to examine the layered barriers to provision of gender affirming health care. Particularly, it focuses on mining the perspectives of practitioners with significant experience in providing care—in a variety of forms—to gender diverse clients, and introduces a solutions based dialogue in order to generate feasible, immediate policy responses situated in the current context. The intersectionality framework grounds this project with health equity roots, and draws attention to the impacts of diverse and intersecting social locations within the gender diverse population.

Further, utilizing a broader definition of health and well-being meant that interview participants included a range of community practitioners providing different services at different levels of care, allowing the study to capture a fuller picture of care challenges facing a variety of providers, and access challenges facing gender diverse clients. Finally, by focusing on generating qualitative data from experts in trans-gender care, the research calls for further consideration of how the knowledge of practitioners and community members can be best maximised and disseminated.

This study is also particularly valuable in that it provides realistic policy interventions that are both economically and politically feasible. While many of the barriers to improving health outcomes for gender diverse people are broad systemic power issues, immediate action is required to improve the access and quality of care options in B.C. This study identifies and evaluates multiple low cost policy options that can be implemented in the short term to improve the health and well-being of the gender diverse population.

9.3. Future Directions

This project focuses on generating immediate, feasible policies that can directly impact the accessibility and quality of care experienced by the gender variant population in B.C. However, the interviews highlighted that such changes, while vital to day-to-day experiences, nonetheless occur within a broader context; this context sets the stage for the current conditions, and will continue—to a large extent—to define them. Much of the work that needs to be done to improve the health and well-being of gender variant people in B.C. must occur on a larger scale—from the level of a health authority, as well as provincially, nationally, and internationally. The medicalization and pathologization of gender variance, which frames trans- people as mentally ill and creates a gatekeeping dynamic, acts as a significant barrier to both accessing and providing quality gender affirming care; such barriers will require continued efforts at all levels in order to realize change. Other systemic frameworks present significant barriers to improving access to quality gender affirming care: particularly, the fee-for service payment system, and the two-gendered care structure that pervades all levels of health care. Such barriers reflect the binary understanding of gender upon which Western society is anchored. Clearly,

improving the health and well-being of the gender variant population is a challenge that extends far beyond the direct purview of health policy. In order for gender-affirming health care to be truly accessible to all citizens, provincially, nationally, and internationally, foundational shifts in social and medical understandings of gender variance need to occur. Funding needs to reflect the level of demand for gender affirming health care. Further, health care as a whole needs to continue to improve its ability to address the needs of people who are differently abled, gendered, sexed, sized, coloured, sexually oriented, and privileged. The ability to better address the impact of intersections between such social locations is a crucial step in providing more effective and equitable health care. Even among the progressive, dedicated, and innovative professionals who participated in the interviews, the intersecting nature of social locations and social structures on the gender diverse receives limited consideration—a reality produced by the range of urgent trans- needs and strained resources, but which is likely to be heightened among less experienced providers. Indeed, our health care system continues to operate under a limited conceptualization of health; developing a system and policies which better account for the interconnected nature of inequities and experiences is paramount to improving health outcomes for the population as a whole, but particularly the most vulnerable. Realizing such changes may take time, but also work.

Continuing research is an important component to improving the availability of gender-affirming health care, whether it is used to justify the cost of programs, or to determine priority issues. The data generated by the Ontario TransPULSE survey is invaluable to efforts to improve the care environment for trans- people. This survey was recently adapted and implemented for a smaller survey on Vancouver Island, which identified differences in the demographics and needs of the participating gender-diverse population compared to the results of the Ontario study. Regionally developed initiatives—both research and action oriented—can have significant impacts on the accessibility of appropriate quality care for trans- clients. It may be that small, community-based, participant-driven initiatives are what are needed to drag the health care system forward, into improving health equity for gender diverse clients. Ensuring open communication between pockets and hubs of care, with both each other and especially with under-resourced areas, can help regions harness opportunities for

collaboration, and the sharing of strategies, needs, and best practices as they are developed. The development of local initiatives—such as Trans Connect in the Kootneys—are essential to combating the provincial lack of leadership and continual shortage of financial support for a growing area of need. Change on a practical, tangible level cannot wait for system wide progress, but must surge ahead in spite of lingering transphobia and lack of awareness, with the hopes that it can provoke broader change down the road.

9.4. Conclusion

Health care continues to be increasingly difficult to provide and access. Complex environments and layered social determinants of health mean that ‘one size fits all’ health care is neither effective nor fair. Failure to address the unique needs of gender diverse clients, and other traditionally marginalized clients at the intersections of discrimination, perpetuates disproportionately poor health outcomes, with serious cost implications for individuals and society as a whole. Improvements to health equity are severely inhibited in the current climate of fiscal austerity. Unfortunately, such austerity defines the policy context for many marginalized populations, highlighting the urgency of finding ways to realize change in fiscally restricted environments. The findings of this research thus have implications for other marginalized populations struggling with financial barriers to improving care. This research identifies opportunities to more effectively utilize existing resources, and underscores the importance of increasing communication and collaboration among a broad range of stakeholders. This approach has potential for other marginalized groups as well—the value in focusing on better harnessing current resources and the potential benefits to be derived from focused stakeholder collaboration are not population specific, and should be explored in other contexts.

The policy suite recommended provides a centralized location for accurate information, working to counter the pervasive erasure of trans- experience. Further, both the trans-focused website and the mentorship program facilitate engagement and cooperation among health and social practitioners and gender diverse clients. The solutions recommended have limited effectiveness to improve the health outcomes of

gender diverse clients because they address only one element of the issue—provider side barriers—and not address the core issues at play, such as systemic barriers, transphobia and a lack of understanding of gender diversity. These options open the door to immediate positive change in B.C.'s care environment for gender diverse clients, but they are mere stepping-stones on a long path towards sufficient levels of accessible gender-affirming health care in B.C.

Trans repudiation seeps into many areas of society, but health care has a particular responsibility and opportunity to work to mitigate the impact of social determinants and societal discrimination by enabling the effective and equitable provision of physical and mental health care, and transition related treatment if desired. While the health care system plays an important role in mitigating the layered effects of trans- phobia, is far from a panacea. Community initiatives have an important ability to improve day-to-day care options for the gender diverse, but are limited in their effectiveness by the two-gender context in which they are implemented. Substantive change requires substantive action. Pervasive societal discrimination against the gender diverse ultimately produces poor health care access and outcomes. Addressing such discrimination must begin at home, in our clinics, but ultimately must be mirrored at a broader level, within the health care system, and society as a whole. As Dr. D., observes:

...People are talking about (trans- health), and you just have to keep pushing on. And some of its education, some of its advocacy, some of its policy. You just keep it on the forefront.

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Appendices

Appendix A:

Semi-Structured Interview Schedule

- What is your background as a provider of services to gender diverse people?
 - What are your experiences in the health care system while responding to the needs of transgender patients?
 - Were you in this field when the Gender Clinic closed?
 - Clinic affiliations?
 - Current project involvement?
- What are some of the key barriers inhibiting change?
 - What systemic barriers have you encountered?
 - Ex: Funding mechanisms, form structures
- What might be the best response to the needs of transgender patients given these barriers?
 - Tele-health, mentorship, community collaboration, support groups, mental health supports
- Can you identify any best practices from specific jurisdictions that address the need of transgender patients?

Appendix B:

Differing international approaches to gender diverse health care

Internationally, the treatment of gender variant people differs significantly, and may not always reflect the jurisdiction's socio-national history. For example, despite the fact that Sweden is a very well developed welfare state, until very recently, Swedish laws included particularly discriminatory policies towards transgender people. Until ruled unconstitutional in December 2012, sterilization was a mandatory requirement in order to legally change one's sex; this regulation was a remnant of 1970's statutes (Nelson, 2013). By contrast, in 2012 Argentina announced a series of important shifts to regulations affecting gender variant citizens. The new regulations are among the most trans- friendly in the world in terms of altering gender on official documents, and allow such changes with no requirements for psychiatric diagnosis or surgery. Further, the regulations also require medical practitioners—both public and private—to provide free hormone therapy and/or gender reassignment surgery to patients, including minors, who request it (Schmall, 2012).

Perhaps nowhere are there more trans-inclusive policies being implemented than in San Francisco. The city is moving to "cover the costs of gender reassignment surgeries for all uninsured transgender residents", citing both equity and financial efficiency rationales. On the equity front, Supervisor Scott Wiener noted that the policy "was discriminating against transgender people by denying them medically necessary health care," while Health Commissioner Cecilia Chung, a transgender woman, addressed the added financial incentive to amend the policy, asserting that "providing these services is quite nominal compared to the benefits that would improve this community's health outcomes, which is pretty much priceless" (Knight, 2012). Approaches to gender diverse health care issues vary significantly internationally.

Appendix C:

Provider Recommended Policy Approaches

Several broad themes of policy approaches were identified in the interviews as having potential to alleviate the range of barriers discussed, specifically: the need for increased education, increased collaboration and communication among stakeholders, and increased funding. This section briefly touches upon these policy ideas as described by interview participants in order to provide context for the policy options presented in the following chapter.

Overwhelmingly, a lack of provider education on all levels was identified as a core, underlying problem needing to be addressed. Participants consistently highlighted the need to emphasize the basic nature of most primary care services for gender variant clients. In particular, participants noted the need to:

(e)ducate physicians about the fact that they don't actually have to know how to care for the person in terms of the transition – that there are people that you can go to who will help you (Justin, Trans- Program coordinator).

Further, they noted a need to continue to develop support systems for primary care physicians to utilize, and train more physicians to do surgeries. The need for “cross-pollination” with specialists in other areas was also noted... “getting the people that are involved surgically... a little bit more sensitized (and educated)” (Dr. D, General Practitioner).

The need for increased collaboration and communication was also a consistent trend, and participants agreed that enhancing community-based supports was an important element of this process. Peer-based supports were seen as central to this process. Participants noted a range of other areas where support for gender diverse clients could be provided. Not-for profit groups are frequently identified as the appropriate party to provide or house such support. This is notable given the acknowledged centrality of such support to health and well-being; the intersection and relationship between community not-for-profits and the health care system immersed as an issue for consideration. The poor accessibility of resources was noted frequently throughout the interviews, and need for better means of locating resources was frequently highlighted, including:

an index of people involved in trans-care. Another would be really up to date resource lists that include not just stuff like support groups....but other things like good places to go for hair removal you know so they can refer patients there... just having really solid updated information like a really good website. (Dr. M, General Practitioner).

This feeling of needing “a list” of resources was brought up often by participants; the idea of a website was posed a number of times as an appropriate vehicle for housing such information.

The need for changes to funding structures was frequently noted throughout the interviews, with participants asserting a need for overall increased funding to support the provision of gender-affirming health care, as well as the need to examine how such funding is distributed. The limitations of the fee for service structure were particularly identified as an opportunity for change.

The Ministry of Health plays a big role. Unless they fund physicians there (there is a serious lack of incentive) – so creating fee codes which make seeing a transgender person economically viable (Dr. T, General Practitioner).

Amending fee codes in the FFS structure might encourage practitioners working outside of community health centres to provide care for trans- clients—or learn about how to do so—if their time was compensated in a fashion comparable to other complex cases. One participant also broached the idea of separating the budget for trans- health care in order to harness efficiencies.

Appendix D:

Cost Estimation for Trans-focused Website

Base costs for developing the website are estimated at \$530, which includes Dreamweaver software for content generation and addition (\$400), a hosting fee (\$120/year) and the domain name (\$10/year).

The remainder of the implementation costs are for the website design. They were estimated utilizing the DesignQuote website, which is accessible at [www. designquote.net](http://www.designquote.net).

The website specifications used to generate the design quote included:

- Custom design
- 40 pages of supplied typed content
- Member registration
- Discussion forum
- RSS news feeds
- Contact form
- Links page
- Site search
- File uploads
- Member administration
- MetaTage keyword optimization
- Search engine submission